1015 S. Hackett Rd. Waterloo, Iowa 50701 319.234.5990

CEDAR Digestive Health Center

CedarValleyGI.com

Procedure Consent

	uthorize the provider selected be tient's own words):	elow to perform the following test/treatme	ent/procedure: (name of test/treatment/procedure	in the			
	□ Ravi Mallavarapu, MD	□ Srinivas Kalala, MD	□ Moaz Sial, MD □ Shima Ghavimi, MD)			
	□ Richard Manfready, MD	□ Kavan Patel, MD	□ Anjana Aggarwal, MD				
	□ Dileepa Pathirannehelage, N	MD □ Taha Ashraf, MD	□ Louma Rustam, MD				
Name of the test/treatment/procedure in medical terms (health care worker to fill in):							
		□ Esophagogastroduodenoscopy □ Liver Biopsy	□ Flexible Sigmoidoscopy				
Ву	signing this form, I understan	nd and acknowledge that I have been	informed of the following:				
1.	My medical condition has been explained to me by my provider.						

- The reasons for and the purpose of the recommended test/treatment/procedure has been explained to me.
- The nature of the recommended test/treatment/procedurehas been explained to me.
- The risks and benefits of the recommended test/treatment/procedure have been explained to me.
- The alternatives (including non-treatment) to the recommended test/treatment/procedure have been explained to me.
- All of my questions about the recommended test/treatment/procedure have been answered to my satisfaction.

By signing this form, I acknowledge and understand:

- That the practice of medicine is not an exact science, and that no guarantees have been made to me as to the results of the test/treatment/procedure. I also understand that complications may occur which are beyond the control of the provider.
- That unforeseen conditions my arise during the test/treatment/procedure. I agree that additional, necessary procedures may be performed based on intraprocedural findings and the provider's clinical judgement. Possible procedures with a reasonable likelihood of needing to be performed have been discussed with me.
- 3. The risks, benefits and alternatives to the type and method of anesthesia/sedation have been explained to me. My questions about the anesthesia/sedation have been answered to my satisfaction, and I consent to the administration of such anesthesia/ sedation medications as may be considered necessary or advisable by my physician.

- That the provider may remove tissue or biopsies during the test/treatment/procedure.
- That I may be given a substance during an x-ray to make my body tissue easier to see.
- That pictures or videos of my test/treatment/procedure may be taken, if my provider thinks it is needed for medical reasons.
- That someone may watch or help with my test/treatment/procedurefor medical teaching purposes.
- That if my provider thinks I need blood or blood products for medical reasons, it will be given.

I have read the above consent form. I under my provider to perform the recommended to		ernatives of the test/treatment/proce	edure. I authorize
Patient Signature	Date	Time	
Witness Signature	Date	Time	
This section is for a minor patient, or patient has legal right to consent for the patient.	without legal rights to sign the cor	nsent. Signature below must be fro	m a person who
Signature of Legal Representative to Patient	Date	Time	
Relationship to Patient			
Witness Signature	Date	Time	

