RIVER VALLEY
AMBULATORY SURGERY CENTER

Authorization for Surgery and/or Special Procedure/Treatment

Patients Name_____ **Birth Date**_____

I authorize Dr. **AJIT KOKKAT**_____to perform the following surgery and/or special procedure/treatment:

UPPER ENDOSCOPY AND COLONOSCOPY WITH POSSIBLE BIOPSY/BALLOON DILATATION/BANDING/POLYPECTOMY/HEMOSTASIS

_____

_____

_____and any other indicated procedures.

And if applicable, I also authorize _____for the purpose of performing the following significant medical/surgical tasks as part of the surgery and/or special procedure/treatment:

_____

Dr. **AJIT KOKKAT**_____has explained:

- The nature, purpose, and benefits of the proposed surgery/procedure/treatment
- The foreseeable risks and consequences of the proposed surgery/procedure/treatment, including
  - Any potential problems that may occur during recuperation
  - The risk that the proposed surgery/procedure/treatment may not achieve the desired objective.
- The alternatives to the proposed surgery/procedure/treatment and the associated risks and benefits to such alternatives.
- The following specific risks of the surgery and/or special procedure:

_____

_____

- I understand that no guarantee has been made about the results of the proposed treatment or special procedure and those questions about the proposed surgery/procedure/ treatment/ have been answered
- I agree to the use of anesthesia and/or sedation/analgesia as required
- I agree to the use of local or topical analgesia as required
- I agree if applicable, to the disposal of any tissue removed
- I also authorize permanent image documentation of my surgery. In addition, documentation images may be used for scientific or educational purposes provided my identity is protected. I agree that any images may be disposed of by River Valley ASC
- I understand that all Do No Resuscitate orders are suspended until I am fully recovered from anesthesia and discharged from the Post Anesthesia Care Unit. If I do not agree with this, my wishes must be documented in the chart and agreed to by the surgeon and anesthesiologist

This consent may be withdrawn by me at any time, prior to the surgery/procedure/treatment.

Signature Patient _____**Date** _____

Signature Guardian _____**Date** _____

Relationship to Patient _____

Signature of physician obtaining informed consent _____**Date** _____

Signature Witness _____ **Date** _____