THE CENTER FOR Digestive Wellness TRICITIES Gastroenterology

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CONSENT FOR HEMORRHOIDAL TREATMENT

I permit Dr. _____ and such other doctors or persons as are needed to assist him to perform the following procedure on me:

HEMORRHOIDAL TREATMENT (SCLEROTHERAPY/BANDING): After anesthesia medications are given into a blood vessel to relax me, a small catheter and a small needle are placed into dilated hemorrhoids with injection of medication to the hemorrhoids, or banding, which places a rubber band around the base of the hemorrhoid.

ALTERNATIVES: Possible alternatives vary for each patient, as some alternatives may be inappropriate for a number of reasons. However, these potential alternatives include surgery, no treatment or other possible alternatives that have been explained to me.

POSSIBLE RISKS AND COMPLICATIONS: (1) Anesthesia medications can cause a slowing or stopping of breathing, which can usually be reversed with other medications. (2) In patients with abnormal or replaced heart valves, artificial joints or vascular surgery grafts, there is a chance of infection. (3) Ulceration or bleeding, if it occurs, can be a complication. (4) Irritation in the vein that was used for administration of medication. (5) Infection. This may require only antibiotic treatment but may also involve surgery for drainage. Blood transfusion or surgery may be necessary because of complications. If any unforeseen condition arises during this procedure, calling in his judgment for additional procedures, operations or medication (including anesthesia and blood transfusion), I further request and authorize him to do whatever he deems advisable.

I know the doctor cannot tell me about every possible risk, alternative, complication or side effect, but I understand that we discussed the major ones. I am also aware that the practice of medicine is not an exact science. It is possible an abnormality, even if present, will go undetected. The result of this missed diagnosis is unknown. I acknowledge that no guarantees have been made to me concerning the results of this procedure.

Any tissue removed will be disposed of by the designated laboratory in accordance with the accustomed practice. I consent to the taking and publication of any photographs in the course of this procedure for the purposes of documentation and medical education. I consent to the participation of medical students, nurses, and residents during my procedure, who are under the direct supervision of my physician.

In the event that a nurse or physician should be exposed to my blood through needle stick or other unforeseen incident, I hereby give my permission for my blood to be drawn and tested for HIV, or any other blood borne pathogen that the physician deems necessary to adequately protect me and my care giver.

The Center for Digestive Wellness is solely owned and operated by Jeffrey P. Fenyves, M.D. and Stephen W. Fry, M.D., and used exclusively for patients of Tri-Cities Gastroenterology.

Do you have a living will or durable power of attorney (advance directive)? ___ yes ___ no.
In the ambulatory setting, if a patient should suffer a cardiac or respiratory arrest of other life-threatening situation, the signed consent implies consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with Federal and State law, the facility is notifying you we will not honor previously signed advance directives for any patient.
If you should be transferred to another health care facility upon leaving our Center, your advance directive will be honored according to the policy of that facility.

My doctor and I have discussed the proposed procedure, its alternatives, possible risks, complications and side effects. I am willing to accept these risks.

I read this form or had it read to me. I understand what the form says and I do not have any unanswered questions.

Signed: _____ **Date:** _____
(By patient or legally authorized to consent for the patient)
Name: _____ **Relationship to Patient:** _____

Witnessed by: _____
NOTE: This facility, or physicians, and employees will not be responsible for any personal items lost during your visit here for your procedure or treatment (jewelry, dentures, glasses, contact lenses, hearing aids, purses, clothing, etc.)