TRESANTI SURGERY CENTER
5201 Norris Canyon Rd, Ste 100
San Ramon, CA 94583
Telephone: 925-973-0605 Fax: 925-973-0653

AUTHORIZATIONS FOR SURGERY, ANESTHESIA,
DIAGNOSTIC OR THERAPEUTIC PROCEDURES

DATE: _____ **SEX: M F PATIENT NAME:** _____

1. I voluntarily authorize Dr._____ and such associates, technical assistants and other health care providers, as they may deem necessary, to perform the following procedure(s):

____ **Esophagogastroduodenoscopy (EGD):** Examining the esophagus (swallowing tube), stomach, and the beginning of the small intestine. This may include biopsy, dilatation (stretching out a narrowing), or treatment of bleeding.

____ **Colonoscopy:** Examining all or a portion of the large intestine. This may include biopsy, removal of polyps, dilation, or treatment of bleeding.

____ **Flexible Sigmoidoscopy:** Examining the lower portion of the large intestine. This may include biopsy, removal of polyps, dilation, and treatment of bleeding.

2. Risks, benefits and alternatives have been explained to me by Dr._____. I have had the opportunity to have my questions answered.

3. I understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I authorize my physician and such associates, technical assistants and other health care providers to perform such other procedures which are deemed advisable in their professional judgment.

4. I understand the risks and hazards related to the procedure such as damage to the lining from the instrument, aspiration, and reactions to medication, gas pains, perforation, infection, bleeding and the consequences.

5. I understand that whenever anesthesia is administered, risks and complications are always possible. Risks range from minor side effects such as nausea or vomiting to potentially serious complications that may be life threatening. Serious complications in relation to anesthesia, are however, very rare.

6. In the event the physician or staff is exposed to my blood, body fluids or contaminated materials, I agree to allow testing that will determine the presence of HIV and Hepatitis or other such transmissible diseases. An accredited laboratory, at no cost to me, will perform all required laboratory tests.

7. I consent to photography during the procedure. Photographs would be used solely for medical documentation.

8. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me about the results or success of this procedure.

9. I consent to the study and retention or disposal of tissue which may be removed during the procedure.

10 I understand that in the event of a life-threatening emergency this center will normally provide medically appropriate emergency care until I can be transferred to an acute care hospital. If I have an advance directive that would affect care in an emergency, I will bring it to the centers attention and discuss how it should apply.

11. I understand that my physician has ownership interest in this surgical facility.

12. I understand the TSC is not responsible for any valuables that I have elected to bring.

TRANSPORATION ARRANGEMENTS

- **I understand that if I am given ANY sedating medication or anesthesia, I MUST have made prior arrangements to have a responsible adult drive me home.**
- **If I am unable to arrange appropriate transportation, the Tresanti Surgery Center will make every effort to arrange transportation for which I will be financially responsible.**
- **ONLY if I receive NO sedating medications will I be able to drive myself home.**

Consent:
I certify I have read and understand the content of this informed consent document and acknowledge advance receipt of the Tresanti Surgical Center Patient Rights and Responsibilities. I also certify all my questions and concerns regarding the procedure, its risks, benefits and alternatives have been explained to my satisfaction. I hereby authorize the physician noted above and/or such assistants as may be selected by him/her to perform the above procedure.

Today Date: _____ _____
Patient's Signature (Legal Guardian or Patient's Representative)

Surgery Date: _____ _____
Witness' Signature

FOR MEDICAL STAFF USE ONLY

I have confirmed the above procedure(s) with the patient (Legal Guardian or Patient's Representative).

Pre-Op RN: _____ Anesthesiologist: _____

Procedure RN: _____ Physician: _____