Massachusetts General Hospital
Founding Member, Mass General Brigham

Patient Identification Area
PATIENT MUST BE IDENTIFIED BY
NAME AND MEDICAL RECORD NUMBER

CONSENT FOR PROCEDURE

I hereby authorize _____ to perform the following procedure(s)

PROCEDURE:

- ☐ Upper Endoscopy – possible biopsy, dilation, control bleeding
- ☐ Colonoscopy – possible biopsy, dilation, control bleeding
- ☐ EGD with Ablation
- ☐ Flexible Sigmoidoscopy – possible biopsy
- ☐ Other: _____

Operative Site: _____

If laterality applies: ☐Right ☐Left ☐Both Sides ☐NA

I have been informed of 1) the potential risks and benefits of the procedure(s); and 2) the risks and benefits of the alternatives, including the consequences of not having the procedure(s).

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the proposed treatment(s) or procedure(s).

Further I am aware that there are possible risks, such as loss of blood, infection or pain that may accompany any surgical, diagnostic or therapeutic procedure. The following additional risks were explained to me:

If procedural sedation will be used during this procedure, I understand that this sedation has risks. My physician has discussed the use of procedural sedation. The risks include but are not limited to slower breathing and low blood pressure that may require treatment.

I understand that a potential risk or complication of the procedure is the loss of blood. I understand that I may require blood products during the procedure or in the post-procedure period. If I refuse blood products, I will complete a separate release for blood-free treatment form.

I understand that one or more healthcare industry professionals (technical representatives for medical equipment and device companies) or observers may be present during this procedure for advisory or observational purposes only.

The hospital may photograph, videotape, or record my procedure/surgery for educational, research, quality and other healthcare operations purposes. Any information used for these purposes will not identify me.

I understand that blood or other samples removed during this procedure may later be disposed of by Massachusetts General Hospital. These materials also may be used by Massachusetts General Hospital, its partners, or affiliates for research, education and other activities that support Massachusetts General Hospital's mission.

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A team of medical professionals will work together to perform my procedure/surgery. The role and involvement of the senior attending in my procedure has been discussed with me, including that he/she may join the procedure after the opening of the surgical site or may leave during the closing of the surgical site, and may need to step away during non-critical portions of the procedure. The roles of additional practitioners involved in the procedure, indicated below, have also been explained to me. I understand that other medical professionals may be involved in the procedure who are not listed below. The name of those practitioners will be shared with me after the procedure.

	Role of Practitioner (check all that apply)	Name of Practitioner if known
	Fellow.	
	Resident. Specify Year:	
	Physician Assistant	
	Advanced Practice Nurse	
	Other, please specify:	
	Other, please specify:	

☐ My surgeon has informed me that my surgery is scheduled to overlap with another procedure she/he is scheduled to perform. I understand that this means my surgeon will be present in the operating room during the critical parts of my surgery but may not be present for my entire surgery. I understand that my surgeon or another qualified surgeon will be immediately available should the need arise during my surgery.

I have had a chance to ask questions about the risks, benefits, side effects, likelihood of achieving the goals of this procedure, and other approaches. All my questions were answered to my satisfaction and I give permission to have the procedure.

Patient/Surrogate Decision Maker Signature	Printed Name if not Patient	Date	Time	AM PM
Practitioner Obtaining Consent Signature	Printed Name	Date	Time	AM PM

Attending Physician/Primary Practitioner Attestation (not required if individual obtained original consent)
I attest that I discussed all relevant aspects of this procedure/surgery, including the indications, risks, and benefits, as compared with alternative approaches with the patient or surrogate decision maker, answered their questions, and provided information regarding other medical professionals who will be present during the surgery.

Attending Signature	Printed Name	Date	Time	AM PM

If interpreter was used please complete name or number of interpreter: _____

Telephone Consent
Date: _____ Time: _____ AM PM
Reason for Telephone Consent:_____
Surrogate Decision Maker Name:_____
Consent Received by:_____
Consent Witnessed by:_____