BRONSON	Affix Patient Label
	Patient Name: DOB:

I agree that Dr._____ can perform
Duodenoscopy With Possible Biopsy / Polypectomy / Possible Esophageal Dilatation Procedure.

_____
_____
_____
_____

Benefits of this Surgery/Procedure:
Your doctor cannot promise you will receive any benefits. Only you can decide if the benefits are worth the risk.

- _____
- _____
- _____

Risks of this Surgery/Procedure:
No procedure is completely risk free. Some risks are well known. There may be risks that your doctor can't expect.

- _____
- _____
- _____

General Risks of Surgery/Procedure:

- **Small areas of the lungs may collapse**. This would increase the risk of infection. This may need antibiotics and breathing treatments.
- **Clots may form in the legs, with pain and swelling**. These are called DVTs or deep vein thrombosis. Rarely, part of the clot may break off and go to the lungs. This can be fatal.
- **A strain on the heart or a stroke may occur.**
- **Bleeding may occur.** If bleeding is excessive you may need a transfusion.
- **Reaction to the anesthetic may occur.** The most common reactions are nausea and vomiting. In rare cases, death may occur. The anesthesiologist will discuss this with you.

Risks associated with smoking:
Smoking is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks associated with obesity:
Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

General Information:

- During this procedure, the doctor may need to perform more or different procedures than I agreed to.
- During the procedure the doctor may need to do more testing or treatment.
- Tissues or organs taken from the body may be tested. They may be kept for research or teaching. I agree the hospital may discard these in a proper way.
- Students, technical sales people and other staff may be present during the procedure. My doctor will supervise them.
- Pictures and videos may be done during the procedure. These may be added to my medical record. These may be published for teaching purposes. My identity will be protected.

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Medical Implants or Explants:
I agree to the release of my social security number, my name and address, and my date of birth to the company that makes the medical device that is put in or removed during this procedure. Federal laws and rules require this. The company will use this information to locate me, if needed.

By signing this form I agree:

- I have read this form or had it explained to me in words I can understand. I understand its contents.
- I have had time to speak with the doctor. I have had my questions answered.
- I want to have this procedure: **Duodenoscopy With Possible Biopsy / Polypectomy / Possible Esophageal Dilatation Procedure**
- I understand that my doctor may ask a partner to do the surgery/procedure.
- I understand that other doctors, including medical residents or medical staff will help with surgery. The tasks will be based on their skill level. My doctor will supervise them.

Provider: This patient may require a type and screen or type and cross prior to procedure. IF so, please obtain consent for blood/product.

Patient Signature_____Date:_____Time:_____
Relationship: ☐**Patient** ☐**Closest relative (relationship)_____** ☐**Guardian**

Witness_____Date_____Time_____

Interpreter's Statement: I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.
Interpreter_____Date_____Time_____
(if applicable)

For Provider Use ONLY:
I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Provider signature:_____ Date:_____ Time:_____

Teach Back
I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Patient shows understanding by stating in his or her own words:
____ Reason(s) for the treatment/procedure: _____
____ Area(s) of the body that will be affected: _____
____ Benefit(s) of the procedure: _____
____ Risk(s) of the procedure: _____
____ Alternative(s) to the procedure: _____
OR
____ Patient elects not to proceed: _____ Date:_____ Time:_____
(patient signature)
Validated/Witness:_____ Date:_____Time:_____