Southwest Endoscopy
7788 Jefferson NE, Albuquerque, NM 87109
Phone: (505) 999-1600
Fax: (505) 999-1650
Southwestgi.com

Consent for Medical Procedure or Surgery and Acknowledgement for Receipt of Information

EXPLANATION

A physician obtains the patient's consent to surgery or medical procedure. You are asked to consent to an operation or a medical procedure and confirm that the operation or procedure has been explained to you, that you understand what is to be done, why it is necessary, and risks that may be involved. If you have any doubts or unanswered questions, do not sign the consent. The physician will be called.

CONSENT

The undersigned hereby requests and gives consent to _____
Physician's Name

and assistants of their choice to perform or administer to _____
Patient's Name

the following surgical or medical procedure for diagnosis or treatment:

And to do any procedure(s) that in the judgement of the above-named physician or their assistant may be deemed necessary or advisable based on findings during said operation or procedure. The consent also includes authority to administer any necessary medications chosen by the physicians or their assistants, and the disposal of any tissue removed.

The nature and purpose of this operation or medical procedure(s), possible alternative methods of treatment, the risks involved, and the possibility of complications or unintended results have been explained. I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained.

I acknowledge that I have read and fully understand the above consent, the explanations referred were made, and that all blanks or statements requiring insertion of completion were filled in before I affixed my signature.

DISCHARGE INSTRUCTIONS

IF YOU SHOULD HAVE PAIN, BLEEDING, OR FEVER, YOU SHOULD NOTIFY YOUR DOCTOR IMMEDIATELY.

You may not drive at all on the day of your procedure. You are expected to arrange for transportation with a friend or family member.

Sedation/narcotics may affect your judgment. Important decisions should be postponed for the remainder of the day.

Avoid strenuous activity today. You may resume normal activity tomorrow.

It is recommended that you avoid alcoholic beverages for the remainder of the day.

You may feel drowsy and sleepy following your endoscopy.

Tenderness, swelling, or pain may occur at the IV site where you received sedation. If you experience this, apply ice wrapped in a towel or cloth to the area for 30 minutes two or three times the first day. If you're still sore the next day, apply a warm, moist cloth to the area for 30 minutes two or three times during the day. If the discomfort continues, please call your physician at 505-999-1600.

Tylenol (Acetaminophen) is permitted.

Colonoscopy: You may feel bloated after your exam. This is normal and will usually pass after a short time. Walking will also help in getting rid of the gas.

Colonoscopy: You may not have a normal bowel movement for approximately three days.

Upper GI Endoscopy: If your throat feels sore after you get home, you may gargle with warm salt water, use lozenges, have cold drinks or popsicles to relieve any discomfort.

Your doctor will be providing you with additional recommendations specifically relating to the results of your procedure.

If you have any questions regarding the above instructions, please call our office at (505) 999-1600.

ACKNOWLEDGEMENT OF RECEIPT AND ACCEPTANCE OF

- Advance Directives
- Notice of Privacy Practices
- Patient Information on Abuse and Neglect
- Patient Rights and Responsibilities
- Physician Ownership
- Financial and Sedation Consent

By signing this form, you acknowledge that you have reviewed the above information, you understand the content, and your questions have been answered to your satisfaction.

Our policies are subject to change. You may obtain a copy of the revised policies on our website:

http://www.southwestgi.com or by calling our office at 505-999-1657.

If you have questions regarding our policies, please call 505-999-1657.

I acknowledge receipt of the Southwest Endoscopy policies listed above.

Signature of Patient or Legal Representative _____

If not patient, indicate relationship

Witness _____

Date: _____ Time: _____

Patient Identification

_____

Name

_____

Date of Birth

_____

MRN

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