Piedmont Endoscopy Center
1901 S. Hawthorne Rd. Suite 308
Winston-Salem, NC 27103

Salem Endoscopy Center
875 Bethesda Rd.
Winston-Salem, NC 27103

Gastroenterology Associates of the Piedmont, P.A.

Accredited by AAAHC
ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

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CONSENT FOR PROCEDURE(S)

I request that Dr. _____ perform the following procedure(s) on me:

☐ Upper Endoscopy / Biopsy
☐ Upper Endoscopy / Esophageal Dilatation
☐ Other: _____
☐ Colonoscopy / Biopsy / Polypectomy
☐ Flexible Sigmoidoscopy / Biopsy

I understand and voluntarily consent to the following:

1. Procedures and/or operations that are presently unknown may be performed that are different from or in addition to those planned in the case that the doctor or his/her associates or assistants consider them advisable or necessary.
2. I consent to the administration of moderate or deep sedation/anesthetics (by mouth or through a needle placed in a vein in my arm or hand) as considered necessary or advisable by the physician, certified registered nurse anesthetist, and/or registered nurse under supervision of the physician. I understand the alternatives, the risks involved, and possible complications of sedation.
   - Moderate sedation is a drug-induced depression of consciousness during which patients may purposefully respond to verbal command, either alone or by light tactile stimulation. Cardiovascular function and spontaneous breathing are maintained throughout the procedure.
   - Deep sedation is a drug-induced depression of consciousness during which patients cannot be easily aroused, but respond purposefully following repeated or painful stimulation. Cardiovascular function is maintained, but patients may require assistance in maintaining an open airway throughout the procedure.
3. Teeth in poor condition and dental prosthetics may become loose, broken, or dislodged during endoscopy and/or during the protective procedures related to anesthetic. While every effort is made to protect my teeth, such damage is a recognized risk of endoscopy. Gastroenterology Associates of the Piedmont will not accept responsibility for damage to teeth or dental prosthetics.
4. Any tissues that are removed during my procedure(s) may be reviewed by a pathologist.
5. Photos and/or video may be taken as considered advisable or necessary by the doctor.
6. Doctors in training may be present and participate during the procedure(s).
7. The adult accompanying me may be given my discharge instructions.
8. I will not drink alcohol, take tranquilizers or sedatives, or drive/operate machinery for eight hours after discharge from the procedure(s).
9. Gastroenterology Associates of the Piedmont will not honor prior Advanced Directives or a Do Not Resuscitate order.
10. Gastrointestinal endoscopy is generally a safe and effective way to examine the gastrointestinal tract. It is not 100 percent accurate in diagnosis. No guarantee has been given by anyone as to the result of the procedure(s). Other options are available, including (but not limited to) radiologic studies, surgery and medical treatment. A GAP physician will be happy to discuss these alternatives.
11. The nature and purpose of the procedure(s) along with its risks and potential complications have been explained to me. All of my questions have been answered to my satisfaction, and I believe that I have enough knowledge to base an informed consent to the proposed procedure(s).

Signature of Patient *(or person authorized to consent)*: _____

Relationship: ☐ Patient ☐ Other: _____

Witness: _____

Date: _____ Time: _____ AM / PM

{ PLACE LABEL HERE }

Physician: _____, MD