This form is provided as a courtesy and should not be construed as legal advice.

PATIENT INFORMED CONSENT

1. OPERATION OR PROCEDURE ALTERNATIVES:

I_____, (patient or guardians) authorize Doctor Schron/ Bracher/ Amin/ S. Patel/ Y. Patel along with associates and assistants of his or her choosing, to perform the following operation or other procedure: Upper endoscopy with possible biopsy, dilatation, cautery or injection of bleeding lesion or polypectomy.

I understand the reason for the procedure is: _____.

Alternatives include: upper GI barium x-ray

2. RISK: This authorization is given with the understanding that any operation or procedure involves some risks and hazards. Some of the significant risks of this particular procedure are:

- Bleeding
- Infection
- Cardiac or pulmonary problems related to the stress of the procedure and/or the medications used for sedation
- Perforation (hole) requiring surgery to repair

I also understand that the more common risks of any procedure include: infection, nerve injury, blood clots, heart attack, allergic reactions and pneumonia. These risks are serious and possibly fatal.

3. ANESTHESIA: The administration of anesthesia also involves serious risks, most importantly a rare risk of reaction to medications causing death. I consent to the use of such anesthetics as may be considered necessary by the person responsible to these services except: _____none_____ (if none, write "none")

4. ADDITIONAL PROCEDURES: If my physician discovers a different, unsuspected condition at the time of the procedure, I authorize him or her to perform other such procedures as deemed necessary, except: ___none___ (if none, write "none")

5. RESULTS NOT GUARANTEED: I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure my condition.

6. PATIENT'S CONSENT: I have read and fully understand this consent form and understand I should not sign this form if all items, including my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form. I have no further questions.

IF YOU HAVE QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED PROCEDURES, ASK YOUR PHYSICIAN BEFORE SIGNING FORM.

DO NOT SIGN UNLESS YOU HAVE READ AND THROROUGHLY UNDERSTAND THIS FORM.

Witness_____. Patient/Responsible Party_____.

Date_____ Time_____am/pm

PHYSICIAN DECLARATION: I have explained the contents of the document to the patient and have answered all the patient's questions and to the best of my knowledge, the patient has been adequately informed. The patient has consented.

Physician's Signature_____ Date_____ Time_____am/pm