Oregon Endoscopy Center
Eugene Gastroenterology Consultants, P.C.
Oregon Endoscopy Center
3355 RiverBend Drive Suite 510 Springfield, OR 97477-8800
(541) 868-9500 (541) 685-5920 Fax

Patient:	Patient Test		
MRN:	000000000		
DOB:	1/1/1965	**Procedure:**	Colonoscopy
Gender:	Male	**Date:**	8/23/2023
Age:	58 year(s)	**Attending Physician:**	Test, Doctor

Procedure Consent

AUTHORIZATION FOR AND CONSENT TO PROCEDURE, ADMINISTRATION OF SEDATIVES/ANESTHETICS/CONSCIOUS SEDATION AND RENDERING OF OTHER MEDICAL SERVICES

1. The Oregon Endoscopy Center maintains personnel and facilities to assist your physician in the performance of various diagnostic and therapeutic procedures. These procedures have risks that include but are not limited to: perforation and bleeding. The risks of anesthesia and/or conscious sedation include but are not limited to respiratory/cardiac arrest or even death. A small percentage of polyps and other lesions can be missed with any procedure. There is no guarantee of any result or cure resulting from your procedure.
2. You have the right to be informed of such risks as well as the nature of the procedure, the expected benefits or effects of such procedure, and the available alternative methods of treatment and their risks and benefits. Procedures are not performed until you have had the opportunity to receive this information and have given your fully informed consent. You have the right to consent or to refuse any proposed procedure any time before its performance.
3. Your physician has recommended the procedure(s) set forth above. Upon your authorization and consent the procedure set forth above, together with any different or further procedures which in the opinion of the supervising physician may be indicated due to an emergency, will be performed on you. The procedures will be performed by the physician named above (or in the event of an emergency causing his/her inability to complete the procedure, a qualified substitute physician); together with associates and assistants from the medical staff to whom the physician may assign designated responsibilities.
4. The pathologist is hereby authorized to use his/her discretion in disposing of any member, organ, or other tissue removed from you, the patient's person, during the procedure(s) set forth above.
5. I have a responsible adult available to drive me home.

I hereby acknowledge that my physician has provided me with information about the procedure above. I have been fully informed of the risks and possible complications of the procedure, and alternative procedures or methods of treatment. I have been asked if I want a more detailed explanation, and I have been satisfied with the explanation given or did not want any more information, or I requested and received, in substantial detail, further explanation of the procedures, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment.

Signatures

Patient or Legal Guardian Signature
08/23/2023 09:22 AM

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Staff Witness Signature
08/23/2023 09:22 AM