Bay Area Gastroenterology ASSOCIATES

Dr. Jigneshkumar B. Patel, M.D.
Board Certified Gastroenterologist

Consent for Hemorrhoid banding procedure

Patient Name: _____ **Date of birth:** _____

I understand and acknowledge that during the course of my treatment today, the following procedure(s) may be required:

The banding of a hemorrhoid, an anoscopy, rigid proctor-sigmoidoscopy, the removal of an anal lesion and or the treatment of the ano-rectum with possible use of local anesthesia.

Prophylactic treatment with antibiotics.

I acknowledge and understand that prior to any procedure(s) being performed, the physician will give me more specific instructions. The physician will explain the diagnosis, and I will have an opportunity to ask questions and have those questions answered. The procedure(s) will proceed only when I have given a verbal informed consent and signed this written informed consent.

RISKS

I understand that the practice of medicine is not an exact science and acknowledge that I have not received any guarantees, assurances, or promises concerning the results of the procedure(s). I understand that as a result of the performance of the procedure(s), there is a minor risk that I may suffer pain, urinary symptoms, and loss of blood, infection, or allergic reaction, along with a risk of recurrent hemorrhoid symptoms.

The potential benefits and likelihood of success with treatment are very good. I understand and acknowledge that there are alternatives to treatment such as (but not limited to) invasive surgery, infrared coagulation, over the counter (OTC) medications, and not seeking treatment (i.e., living with the condition(s)). If the procedure is rejected, the future prognosis is unknown at this time.

I acknowledge and understand that during the course of the procedure(s), conditions may develop that may reasonably necessitate an extension of the original procedure(s) or the performance of procedure(s) that are unforeseen or not known to be needed at the time this consent is obtained. In the event of such unforeseen circumstances, I consent to my treating physician providing treatment to me that he or she deems medically necessary.

I acknowledge and understand that this request for a consent to surgical and/or diagnostic procedures shall be valid for the responsible physician, all medical personnel under the direct supervision and control of the physician, and for all other medical personnel otherwise involved in the course of treatment.

By signing below, I acknowledge that I have read this form and had this form read and/or explained to me and that I fully understand this form. I also acknowledge that I have been given ample opportunity to ask questions, and any questions I have been answered or explained in a satisfactory manner. In signing, I acknowledge that I understand the relative risks, potential benefits, and alternatives for hemorrhoidal therapy, and I voluntarily consent to allow Dr. Patel or any physician designated or selected by him or her and all other personnel that may otherwise be involved in performed such procedure, to perform the procedures described or referred to herein. I also acknowledge that I understand and consent to the fact that vendors or to her observers may be present during the performance of my procedure(s).

_____

Signature of patient or person signing on behalf of patient Date/Time

_____

Signature of witness Date/Time

Appointments:

1st Hemorrhoid Treatment: _____

2nd Hemorrhoid Treatment: _____

3rd Hemorrhoid Treatment: _____

Follow Up Hemorrhoid Treatments: _____