GI Excellence, Inc.
Gastroenterology Associates

PH: (951) 652-2252 | Office Fax: (951) 658-6476
Office Hours: 9 a.m. to 5 p.m., M-F

Procedure to be at this location:

Hemet Endoscopy Center
Informed Consent for Gastroenterology Related Procedures
1003 E. Florida Avenue, Suite 104, Hemet CA 92543
(951) 652-2252

CONSENT FOR PERFORMANCE OF INFRARED COAGULATION (IRC) OR BAND LIGATION OR I&D OF THROMBOSED HEMORRHOID

A. IDENTIFICATION

Patient Name:_____ SSN:_____

OPERATION OR PROCEDURE:

- ☐ Infrared Photocoagulation ☐ Single Treatment Session ☐ Multiple Treatment Sessions
- ☐ Hemorrhoidal Band Ligation ☐ Single Treatment Session ☐ Multiple Treatment Sessions
- ☐ Incision and Drainage of Thrombosed Hemorrhoid ☐ Single Treatment Session

B. STATEMENT OF REQUEST:

The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risk involved and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be USING A LIGHT BEAM THAT GENERATES HEAT ON THE HEMORRHOID. (description of operation in layman's language) A SMALL AMOUNT OF INFRARED ENERGY WILL BE RELEASED CAUSING A DECREASE IN THE SIZE OF THE HEMORRHOID, WITH POSSIBLEPLACEMENT OF A BAND. This procedure is to be by or under the direction of Dr. _____.

RISKS INCLUDE: PAIN, BLEEDING, INFECTION AROUND THE HEMORRHOID, AND ADVERSE DRUG REACTION.

I request the performance of the above-named operation or procedure and of such additional operations or procedures that are found to be necessary or desirable in the judgment of the professional staff of GI Excellence, Inc. during the course of the above named operation or procedure.

I request the administration of such anesthesia as may be considered necessary or advisable in the judgement of the professional staff of GI Excellence, Inc.
Exceptions to surgery or anesthesia, if any, are: _____.
(If none, so state)

I request the disposal by authorities of GI Excellence, Inc. of any tissues or parts; which it may be necessary to remove.

C. SIGNATURES: (appropriate items in part A and B must be completed before signing)

COUNSELING PHYSICIAN or NURSE: I have counseled this patient as to the nature of the proposed procedure(s).

_____ _____
Signature of Counseling Physician or Nurse Date

Continued next page.

PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved and expected results, as described above, and hereby request such procedure(s) be performed.

_____	_____	_____
Signature of Witness	Signature of Patient	Date

SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor / guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved and expected results, as described above, and hereby request such procedure(s) be performed.

_____	_____	_____
Signature of Witness	Signature of Patient	Date

To learn more of G.I. Excellence, Inc.'s procedures and patient care technology, visit our website www.gi-excellence.com.