GI Excellence, Inc.



A. IDENTIFICATION

Gastroenterology Associates

Milan S. Chakrabarty, M.D. General Gastroenterology

Indraneel Chakrabarty, M.D., M.A. Gastroenterology Interventional & Advanced Endoscopy Sandra Del Valle, PA-C Gastroenterology Physician Assistant

Kathleen Linke, PA-C Gastroenterology Physician Assistant

Two Locations:

1003 E. Florida Avenue · Suite 101 Hemet, CA 92543

31515 Rancho Pueblo Rd. · Suite 202 Temecula, CA 92592

www.gi-excellence.com · PH: (951) 652-2252 Office Fax: (951) 658-6476 Office Hours: 9 a.m. to 5 p.m., M - F

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

Patient Name:	SSN:	
OPERATION OR PROCEDURE: Infrared Photocoagulation Hemorrhoidal Band Ligation Incision and Drainage of Thro		Multiple Treatment Sessions Multiple Treatment Sessions Single Treatment Session
B. STATEMENT OF REQUEST:		
the possibility of complications hav concerning the results of the opera A LIGHT BEAM THAT GENERATES AMOUNT OF INFRARED ENERGY WI	operation or procedure, possible alternative mee been fully explained to me. I acknowledge to ation or procedure. I understand the nature of HEAT ON THE HEMORRHOID. (description of ILL BE RELEASED CAUSING A DECREASE IN THE dedure is to be by or under the direction of Dr	that no guarantees have been made to me of the operation or procedure to be USING operation in layman's language) A SMALL SIZE OF THE HEMORRHOID, WITH POSSIBLE
RISKS INCLUDE: PAIN, BLEEDING,	INFECTION AROUND THE HEMORRHOID, A	AND ADVERSE DRUG REACTION.
	above-named operation or procedure and of suble in the judgment of the professional staff of re.	
I request the administration of professional staff of GI Excellence, Ir	such anesthesia as may be considered neces nc.	sary or advisable in the judgement of the
Exceptions to surgery or anesthesia,	if any, are:(If none, so star	te)
I request the disposal by authorit	ties of GI Excellence, Inc. of any tissues or parts	; which it may be necessary to remove.
C. SIGNATURES: (appropriate items	s in part A and B must be completed before sign	ning)
COUNSELING PHYSICIAN or N	URSE: I have counseled this patient as to the n	ature of the proposed procedure(s).
Signature of Counseling Physician or	r Nurse Date	_
PATIENT: I understand the nature above, and hereby request such pro-	e of the proposed procedure(s), attendant risks cedure(s) be performed.	involved and expected results, as described
Signature of Witness	Signature of Patient	Date
sponsor / guardian of	patient is a minor or unable to give consent) I, _ understand the nat as described above, and hereby request such pr	ture of the proposed procedure(s), attendant rocedure(s) be performed.
Signature of Witness	Signature of Patient	Date Patient Information Form Anesthesia 1 25 16