GASTROENTEROLOGY AND HEPATOLOGY CENTER

Sanjeev M. Wasan, M.D., PLC

19420 Golf Vista Plaza, Suite 230, Lansdowne, VA 20176

Phone: 703-724-4480 Fax:703-724-7743

CONSENT FOR ENDOSCOPIC PROCEDURES

Patient: _____ authorizes the performance of one or more of the following procedures:

- ❑ **Colonoscopy** with possible biopsy, polypectomy, control of bleeding, electrocautery, dilation, injection of medication, or other therapy deemed necessary under intravenous sedation.
- ❑ **Esophagogastroduodenoscopy (EGD)** with possible biopsy, polypectomy, control of bleeding, electrocautery, dilation, banding, injection of medication, or other therapy deemed necessary under intravenous sedation.
- ❑ **Flexible Sigmoidoscopy** with possible biopsy, polypectomy, control of bleeding, electrocautery, injection of medication, or other therapy deemed necessary with or without intravenous sedation.
- ❑ **Endoscopic Retrograde Cholangiopancreatography (ERCP)** with possible sphincterotomy, stone removal, stent placement, biopsy, polypectomy, control of bleeding, electrocautery, dilation, injection of medication or other therapy deemed necessary under intravenous sedation.
- ❑ **Small Bowel Enteroscopy** with possible biopsy, polypectomy, control of bleeding, electrocautery, dilation, banding, injection of medication, or other therapy deemed necessary under intravenous sedation.

The risks, benefits and alternatives of the procedure were explained to me and I fully understand them and agree to proceed. Risks include, but not limited to, bleeding, perforation, infection, aspiration, possibility of a missed lesion, reactions to medications used for sedation and death. I understand the possibility of exposure to COVID-19 or any other infectious disease before/during/after my procedure. I have studied the procedure preparation information form. All questions have been answered to my satisfaction. I understand that Dr. Sanjeev Wasan will be the physician performing the procedure. I agree that any body fluids or tissue specimens and radiologic or photographic studies obtained during the course of the procedure may be examined, preserved and/or disposed of in the manner considered appropriate for the purposes of diagnosis and treatment.

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____

Signature of Physician: _____ Date: _____