

The Hospital  
Consent for Performance of Operations or  
other Procedures  
**UPPER ENDOSCOPY**

(Page 1 of 2)  
(Type or Print Firmly - You are making two copies)

for addressograph plate

PATIENT \_\_\_\_\_ DATE \_\_\_\_\_ TIME \_\_\_\_\_ A.M./P.M.

I hereby give my consent and authorize Doctor(s) \_\_\_\_\_ and assisting staff of The Johns Hopkins Hospital to perform the following operation or procedure (the "Procedure"):

Upper Endoscopy

(Identify site, explain in non-medical terms, and use no abbreviations.)

I acknowledge that:

1. The nature and purpose of the Procedure, the risks involved, alternatives and the possibility of complications have been explained to me by Dr(s). \_\_\_\_\_ All my questions, if any, have been answered to my satisfaction. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantee has been made as to the results of the Procedure.
2. If during the Procedure other conditions are discovered which, in the best judgment of the medical staff of The Johns Hopkins Hospital, require something to be done in addition to the Procedure or different from the Procedure, I consent to the additional or different activity being performed.
3. Exceptions to the Procedure, if any, are: \_\_\_\_\_
4. The Johns Hopkins Hospital may dispose of any tissues or parts which are removed during the Procedure. Johns Hopkins may retain, preserve and use these tissues or parts for internal teaching and other educational purposes without my permission even if these tissues or parts identify me. However, Johns Hopkins may only use or disclose tissues or parts that identify me for research with my permission or with the approval of a review board governed by federal laws protecting these activities. If the tissues or parts do not identify me, Johns Hopkins may use them for research purposes without my permission.
5. I understand that The Johns Hopkins Hospital is a teaching hospital and that certain activities may take place for internal teaching purposes and ordinary operational practices. These include the admittance of observers, the use of closed-circuit television, the making of photographs (including motion pictures), and the preparation of drawings and similar illustrative graphic material. Johns Hopkins will make every effort to remove all identifiers not necessary for these Johns Hopkins teaching or operational purposes. Use or disclosure of films, photographs or drawings for other purposes will not be made unless Johns Hopkins:
  - gets my permission
  - gets the approval of a review board governed by federal laws protecting research activities or
  - removes the identifiers from these materials so that my identity is not revealed by the materials or by the descriptive text accompanying them.
6. I will receive a copy of this consent after I sign it.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Witness

ID NO: \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician/Health Care Provider Securing Consent

**IF PATIENT IS UNABLE TO SIGN OR IS A MINOR, COMPLETE THE FOLLOWING:**

Patient (is a minor \_\_\_ years of age) or is unable to sign because: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent, Surrogate, Health Care Agent or Legal Guardian

\_\_\_\_\_  
Signature of Witness

The Hospital  
Consent for Performance of Operations or other  
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**UPPER ENDOSCOPY**

(Page 2 of 2)

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Date: \_\_\_\_\_

for addressograph plate

1. INDICATIONS FOR THE OPERATION OR OTHER PROCEDURE ARE:

\_\_\_\_\_

2. MAJOR RISKS AND PROBABILITY OF SUCCESS OF THE OPERATION OR OTHER PROCEDURE (including such items as failure to obtain the desired result, discomfort, injury, additional therapy and death):

**Reaction to medication (including shock), pneumonia, bleeding, perforation (rare but might require surgery), no diagnosis**

\_\_\_\_\_

3. DISCUSSIONS OF ALTERNATIVES TO THE PROPOSED OPERATION OR OTHER PROCEDURE including risks, benefits and side effects as well as possible outcome of not receiving the procedure:

**Not to perform test**

\_\_\_\_\_

4. IN INSTANCES WHERE A DISCUSSION OF THE ABOVE IS DEEMED UNWISE MEDICAL PRACTICE, THERE SHOULD BE DOCUMENTED A STATEMENT TO THIS EFFECT BELOW, STATING THE REASON FOR THIS DECISION. (This space may also be used for explanatory diagrams.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Signature of Physician/Health Care Provider Securing Consent

ID NO: \_\_\_\_\_

**IF PATIENT IS UNABLE TO SIGN OR IS A MINOR, COMPLETE THE FOLLOWING:**

Patient is a minor (\_\_\_ years of age) or is unable to sign because: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent, Surrogate, Health Care Agent or Legal Guardian

\_\_\_\_\_  
Signature of Witness

**\*\*\*\*\*TIME OUT VERIFICATION\*\*\*\*\* - Please document the names of the participants below:**

\_\_\_\_\_  
Surgeon/Physician/Licensed Health Care Provider

\_\_\_\_\_  
Nurse

\_\_\_\_\_  
Anesthesiologist/CRNA

DATE \_\_\_\_\_

TIME \_\_\_\_\_ AM/PM