GastroIntestinal Diagnostic Center of Howard County
An Endoscopy Center specializing in gastrointestinal procedures.

10805 Hickory Ridge Road
Columbia, Maryland 21044
Phone 410-772-7345
Fax 410-772-8860

MUHAMMAD AFZAL, M.D.
RICHARD ANDORSKY, M.D.
ZAHID W. BUTT, M.D.
KESTER CROSSE, M.D.
ADINARAYANA DIVAKARUNI, M.D.
CHRISTOPHER KIM, M.D.
PRESTON Y. KIM, M.D.
VIJAY NARAYEN, M.D.
NATARAJAN RAVENDHRAN, M.D.
LOUIS A. SALAS, M.D.
HOSSEIN TAVASSOLIE, M.D.
RALPH E. UPDIKE, M.D.
SUSAN KOHNKE, C.R.N.P.

LUCY EVERS, R.N.
Director of Nursing

"Accredited by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC)"

November 23, 2005

Mr. Jack Schwartz
Assistant Attorney General
Director, Health Policy Development
200 Saint Paul Street
Baltimore, MD 21202-2021

Dear Mr. Schwartz,

On behalf of the Howard County Gastrointestinal Diagnostic Center (HCGIDC), we wish to extend our appreciation for communicating the expressed concerns relating to the Center's consent document. Enclosed please find a proof of the revised HCGIDC Consent for Diagnostic and Therapeutic Procedures.

In accordance with the recommended language conveyed by the State of Maryland Advisory Council on Quality Care at the End of Life, Item # 10 has been modified to read, "*I understand that, in the event of a life-threatening emergency, this center will normally provide medically appropriate emergency care until I can be transferred to an acute care hospital. If I have an advance directive that would affect care in an emergency, I will bring it to the center's attention and discuss how it should apply.*"
This revised language represents a more accurate reflection of the Center's position.

Thank you for the comments on this matter. We trust that HCGIDC's prompt response demonstrates our continued commitment to provide the highest level of patient care for our community.

Respectfully submitted,

Richard Andorsky, M.D.
HCGIDC, Medical Director

Lucy Evers, R.N.
HCGIDC, Nursing Director

Cc: The Honorable Elizabeth Boba
Cynda Hylton Rushton, DNSc, RN, FAAN
Chair

Howard County
Gastrointestinal Diagnostic Center
Consent For Diagnostic and Therapeutic Procedures

1. I voluntarily authorize Dr. _____ and such associates, technical assistants and other health care providers, as they may deem necessary, to perform the following procedure(s):

   ____ **UPPER ENDOSCOPY** (an examination of the esophagus, stomach, and duodenum and possible biopsy/polypectomy).
   ____ **COLONOSCOPY** (an examination of all or the major portion of the colon and possible biopsy/polypectomy).
   ____ **FLEXIBLE SIGMOIDOSCOPY** (an examination of the anus, rectum, and last part of the colon and possible biopsy/polypectomy).
   ____ **CAUTERIZATION OR INJECTION THERAPY** (the use of heat or chemical agents applied to a bleeding source).
   ____ **DILATION** (dilating tube or balloons are used to stretch narrow areas of the esophagus, stomach, intestine).
   ____ **PEG REMOVAL** (the removal of a feeding tube in the stomach/intestine).
   ____ **OTHER:** _____

2. Risks, benefits and alternatives have been explained to me by Dr._____. I have had the opportunity to have my questions answered.
3. I understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I authorize my physician and such associates, technical assistants and other health care providers to perform such other procedures, which are deemed advisable in their professional judgement.
4. I understand the risks and hazards related to the procedure such as damage to the lining from the instrument, aspiration, reactions to medication, gas pains, perforation, infection, bleeding and the consequences.
5. I understand that conscious sedation involves additional risks and hazards, but I request the use of sedation for the relief of pain during the procedure(s). I understand that certain complications may result from the use of conscious sedation such as respiratory problems, hypotension, cardiac arrhythmias and drug reaction.
6. In the event the physician or staff is exposed to my blood, body fluid or contaminated materials, I agree to allow testing that will determine the presence of HIV and Hepatitis or other such transmissible diseases. An accredited laboratory, at no cost to me, will perform all required laboratory tests.
7. I consent to photography during the procedure. Photographs would be used solely for medical documentation.
8. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me about the results or success of this procedure.
9. I consent to the study and retention or disposal of tissue which may be removed during the procedure.
10. I understand that, in the event of a life-threatening emergency, this center will normally provide medically appropriate emergency care until I can be transferred to an acute care hospital. If I have an advance directive that would affect care in an emergency, I will bring it to the center's attention and discuss how it should apply.
11. I understand the HCGIDC is not responsible for any valuables that I have elected to bring.

_____ _____
Signature of Patient **Date/Time**

If patient is unable to sign:

_____ _____
Patient Representative/Relationship **Date/**

_____ _____
Witness to Signature **Date/**

I have personally explained the procedure(s), risk, benefits and alternatives.

_____ _____
Physician Signature **Date/**