Cayuga MEDICAL CENTER

A Member of Cayuga Health System

CONSENT FOR SPECIAL PROCEDURES

BLAYK,BONZEANNE R
A00109611111 M000597460
05/01/1956 64 F
Lemberg,Brent D

I hereby authorize Cayuga Medical Center B. Lemberg, MD and his/her associates and such assistants as may be selected by him/her to administer such treatment or diagnostic procedure as is necessary to perform the following procedure:

Colonoscopy (with possible sedation) - *An examination of the large bowel (Rectum and Colon) with a flexible instrument with a possibility of obtaining tissue samples and/or removing growths as needed.*

The nature and purpose of the above procedure, treatment or operation and possible alternative methods of treatment have been explained to me. The possible results, reasonably foreseeable risks, benefits and complications of both the proposed treatment and/or operation and of the alternatives, have also been explained to me. If the physician has included the use of blood or blood components as a purpose or as a risk or consequence of the procedure, treatment, or operation, he/she has discussed the need for, risk of, and alternatives to their administration with me. I have had the opportunity to ask him/her questions that concern me, and he/she has given answers satisfactory to me.

I understand that during the course of the procedure unforeseen conditions may become apparent which require an extension of the original procedure, or a different procedure than that described above. I therefore authorize my physician, his/her associate or assistant to perform such procedures as they, in the exercise of their professional judgement, deem necessary. This consent includes the treatment of conditions which are not known at the time the procedure begins.

I have been informed and understand that there are possible dangers inherent in medical procedures. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me about the results of the treatment or procedure.

I further understand that most members of the medical staff and adjunct medical staff are independent practitioners who are not employed by or under the control of the Medical Center.

I ☐ DO ☒ DO NOT consent to the presence of medical equipment company representatives in the operating procedure room and to their provision of technical support to the operating physician involved in the procedure; in no event does this consent permit performance of a procedure by such representatives.

I ☐ DO ☒ DO NOT consent to moderate sedation/analgesia to tolerate any discomfort that may result from the above procedure. It has been explained to me that all forms of analgesia involve some risks, and that no guarantees or promises can be made concerning the results of my procedure or treatment. I acknowledge the risks of moderate sedation as they apply to my medical condition and have had time to ask questions and consider my decision.

☐ No Sedation

I ☐ do / ☐ do not / ☒ n/a consent to the suspension of my DNR and/or MOLST status from the start of moderate sedation/anesthesia to discharge from the Post Anesthesia Care Unit or Recovery Area.

By signing this form, I affirm that I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I have read and fully understand the above consent for said procedure(s) or treatment(s), the reasons why the above named procedure(s) or treatment(s) may be necessary, the advantages and possible complications, if any, as well as possible alternative modes or treatment(s), which were explained to me.

I hereby assume all risks and accept responsibility for any consequences of said procedure(s) or treatment(s). I release Cayuga Medical Center, its staff and physicians with whom I have consulted about this procedure(s) or treatment(s) from any liability or medical claims in connection therewith.

Bonze Blayk — 1/28/21 1029
(Patient or Representative) (Date and Time)

Melissa Harris RN — 1/28/21 1029
(Witness) (Date and Time)

Physician Attestation: I hereby certify that I have discussed the risks, benefits of, and alternatives to the above procedure(s) with the patient and/or their health care representative, whose questions and concerns have been addressed. The patient and/or their health care representative demonstrates adequate understanding, and desires to proceed with the operation and/or procedure.

B. Lemberg — 1-28-21 1102
(Physician) (Date and Time)