

DIGESTIVE HEALTH ASSOCIATES, P.C.

CONSENT TO IMMUNOSUPPRESSIVE THERAPY WITH 6-MERCAPTOPYRINE (6-mp) OR AZATHIOPRINE (IMURAN®)

This document helps us inform you about this procedure. Please read it carefully and address any questions or concerns you may have personally with the doctor prior to signing it.

Dr. Patrick D. Gerstenberger, Dr. Steven R. Christensen, Dr. Stuart B. Saslow or Dr. Paula M. Dionisio, and his or her assistants are authorized to treat my condition with 6-MP or azathioprine.

ALTERNATIVES: 1. Continuing to try to manage your disease with other non-steroid medication and/or steroids.
2. Surgery.

RISKS: 6-MP and azathioprine are drugs that suppress the immune system. While this effect may help Crohn's disease and ulcerative colitis, these drugs may also cause side effects, some of which can be serious. The more common and serious risks include:

1. Bone marrow suppression (usually reversible), which impairs the body's ability to make essential blood cells. This could lead to life-threatening anemia (low red blood cells), low white blood cells with increased risk for infection, and bleeding due to low platelets.
2. Liver damage, which can be life threatening.
3. Pancreas inflammation.
4. Fever.
5. Joint aches.
6. Possible increased risk for cancer

Complications may occur even when treatment is properly monitored, but it is important to follow your doctor's recommendations for scheduled blood tests to monitor your care.

PATIENT CONSENT

I have had sufficient opportunity to discuss my condition and treatment with my physicians and/or their associates, and all of my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to base an informed consent to the proposed procedure.

I have read and fully understand this form and I voluntarily authorize and consent to this procedure. I understand that I should not sign this form until all my questions have been answered to my satisfaction and until I understand all the words or terms on this form.

I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedure. I have been advised that the proposed procedure may not improve my condition and may, in fact, worsen it.

X _____ Date: _____ Time: _____
Signature of Patient or Authorized Agent

_____ Date: _____ Time: _____
Signature of Witness to Above Signature

*Must be the physician, provider or an assistant who observed the patient or authorized agent sign above.

PHYSICIAN/PROVIDER DECLARATION

I have explained the contents of this document to the patient and have answered all the patient's questions, and to the best of my knowledge, I feel the patient has been adequately informed and has consented.

_____ Date: _____ Time: _____
Physician prescribing treatment