

**DIGESTIVE HEALTH ASSOCIATES, P.C.**

**CONSENT FOR CORTICOSTEROID TREATMENT**

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 steroid medication

- ALTERNATIVES:**
1. Continuing to try to manage your disease with non-steroid medication.
  2. Surgery.

**RISKS:** Corticosteroids (also known as cortisone, steroids, prednisone), when used in high doses for continuous long term treatment (usually longer than three months), may cause side effects, some of which can be serious. The more common risks include:

1. Thinning of bones (osteoporosis) which may lead to fractures or compressions, especially true of vertebral bodies (backbone).
2. Loss of blood supply to bones (osteonecrosis) which may cause severe bone pain, fractures (especially of the hip and shoulder) and may require surgery, including an artificial joint.
3. High blood pressure.
4. Increased pressure in the eye (glaucoma) which can damage vision.
5. Permanent clouding of vision in one or both eyes (cataracts), which can require surgery.
6. Weight gain with increased appetite and fluid retention.
7. Facial fullness.
8. Increase in body hair and acne and a tendency to easy bruising and thinning of the skin.
9. Interference with growth (in children and teenagers).
10. Muscle cramps and joint pain.
11. Changes in the menstrual cycle.
12. Elevation in blood sugar (diabetes).
13. Suppression of your adrenal glands ability to make necessary cortisone at times of physical stress (adrenal insufficiency).
14. Irritation of stomach and esophagus with possible ulcer type symptoms and, rarely, bleeding.
15. Emotional disturbances
16. Increased susceptibility to serious infections.

Complications may occur even when treatment is properly monitored.

*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