INFORMED CONSENT FOR GASTROSCOPY WITH OR WITHOUT DILATATION

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure. ***Has your physician informed you, to your satisfaction about the procedure proposed for you, along with the risks involved?***
_____ Y _____ N _____INITIALS

I voluntarily request Dr. **<MD name>** as my physician, and such associates, technical assistants and other health care providers as they may deem necessary, to treat my condition which has been explained to me as: **<admitting diagnosis>.**

I understand that the following surgical, medical, and/or diagnostic procedure is planned for me and I voluntarily consent and authorize this procedure: **Esophagogastroduodenoscopy (EGD).**

Blood products are not administered at this Center. In the event of complications requiring transfusion, you would be transferred to a hospital. Consent to transfusion allows pre-transfusion care to be initiated.

I (do) (do not) consent to the use of blood and blood products as deemed necessary. I understand the risks of blood transfusions include: fever; transfusion reaction, which may include kidney failure and or anemia; heart failure; hepatitis; AIDS; or other infections. _____ INITIALS

Direct visualization of the esophagus, stomach and the beginning portion of the small intestine with lighted instruments is referred to as an upper gastrointestinal endoscopy or gastroscopy. Your physician has advised you of your need to have this type of examination. The following information is presented to help you understand the reasons for and the possible risks of these procedures.

During your examination, the lining of the digestive tract will be inspected thoroughly. If an abnormality is seen or suspected, a small portion of tissue may be removed for microscopic study (biopsy), or the lining may be brushed and sent for special study of abnormal cells (cytology). Small growths can frequently be completely removed (polypectomy). This test is the best available to examine the digestive tract but it is not perfect, and rarely it can miss a significant growth.

If dilatation (stretching or breaking scar tissue) is required, this is accomplished by passing plastic tubes through the area of narrowing with or without endoscopic guidance.

PRINCIPAL RISKS AND COMPLICATIONS

- The frequency of complications with upper gastrointestinal endoscopy is small. Passage of the instrument may cause an injury to the esophageal, stomach or small intestinal wall with subsequent leakage of its contents into the body cavity. Although this is a rare occurrence, a major surgical procedure to close the hole and/or drain the region is usually required.
- Bleeding, if it occurs, is usually a complication of biopsy, polypectomy, or dilatation. Management of this complication may consist of careful observation, blood transfusions, and/or surgery.

- Adverse reactions to drugs may also occur. The most common reaction is the development of a painful swelling to the vein or surrounding tissue. Discomfort occurring as a result of this irritation may persist for several weeks to several months. Other drug related problems may also occur, to include respiratory depression, low blood pressure, and other less common reactions. In addition, complications from other associated diseases which you may have, such as a stroke or heart attack, are possible. Death, although extremely rare, remains a remote possibility. Your physician will discuss the incidence of complications with you, if you desire, with particular reference to your own personal medical condition. YOU MUST ASK YOUR PHYSICIAN IF YOU HAVE ANY QUESTIONS ABOUT YOUR TEST.

ALTERNATE PROCEDURES AVAILABLE

Although an upper gastrointestinal endoscopy (gastroscopy) is an extremely safe and effective means of examining the upper gastrointestinal tract, it is not 100% accurate in diagnosis. In a small percentage of cases, a failure of diagnosis or misdiagnosis may result. There are other diagnostic or therapeutic procedures available, which would include X-rays and surgery. Your physician will be happy to discuss these procedures with you if you desire.

CONSENT

I (We) understand the above information regarding gastrointestinal endoscopy, and I have been fully informed of the risks and possible complications thereof; I hereby authorize and permit my physician to perform upon me the procedure designated above. If any unforeseen condition arises during this procedure, calling in his/her judgment, for any additional procedures, operation or medications, I further request and authorize him/her to do whatever he/she deems advisable. I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me concerning the results of this procedure.

I (We) consent to my anesthetic care administered by an anesthesia provider or my physician.

I (We) understand that anesthesia/intravenous sedation involves additional risks and hazards, but I (we) request the use of anesthetics/medication for the relief and protection from pain during the planed and additional procedures. I (We) realize the anesthesia may have to be changed possibly without explanation to me (us).

I (We) understand that serious, but rare, complications can occur with all anesthetic/analgesic methods. Some of these risks are breathing and heart problems, aspiration pneumonia, drug reactions, nerve damage, injury to teeth, vocal cords, eyes, or airway, cardiac arrest, brain damage, paralysis, or death. I (we) also understand that other complications may occur. Those complications include but are not limited to: memory dysfunction/memory loss, medical necessity to convert to general anesthesia, or permanent organ damage.

I (We) have been given the opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give this informed consent.

I (We) certify this form has been fully explained to me; that I (we) have read it or have had it read to me and that the blank spaces have been filled in, and that I (we) understand its contents.

_____

SIGNATURE OF PATIENT OR OTHER LEGALLY RESPONSIBLE PERSON

_____

(RELATIONSHIP TO PATIENT)

_____ _____

DATE TIME

_____

SIGNATURE OF WITNESS

WITNESS ADDRESS:
Medical Center Endoscopy
6560 Fannin, Suite 600
Houston, Texas 77030

PATIENT IDENTIFICATION**: <Name, Date of Birth, Age, Physician, Sex, Date of Service, MRN>**