# INFORMED CONSENT FOR ESOPHAGOGASTRODUODENOSCOPY WITH OR WITHOUT DILATION

Direct visualization of the esophagus, stomach, and the beginning portion of the small intestine with lighted instruments is referred to as 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 a special study of abnormal cells (cytology). Small growths can frequently be completely removed (polypectomy). Specimens taken during your procedure will be sent to the laboratory for microscopic examination.

If dilation (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 exceedingly rare. Passage of the instrument may cause an injury to the esophageal wall, stomach, or small intestine with subsequent leakage of its contents into a body cavity. If this occurs, 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 dilation. Management of this complication may consist of careful observation, blood transfusion, and/or surgery.

To provide comfort and relaxation during the procedure, medications which produce moderate sedation (conscious sedation) will be administered through an intravenous solution. Moderate Sedation (conscious sedation) is a minimally decreased level of consciousness which allows the patient to retain the ability to breathe independently and to respond appropriately to touch and/or verbal commands. There is no loss of consciousness.

Adverse reactions to medications given for sedation may occur. The most common reaction is the development of a painful swelling of the vein or surrounding tissue. Discomfort occurring as a result of this infiltration may persist for several weeks to several months. Other medication related problems which may also occur include, but are not limited to, respiratory depression, low blood pressure, and other less common reactions.

If you have never received any of the medications that you will receive today, neither you nor your physician would have any reason to expect an allergic reaction. However, this can happen. Allergic reactions include, but are not limited to, skin rash, irregular heart rate, difficulty breathing, and anaphylactic shock. 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.

**ALTERNATE PROCEDURES AVAILABLE**

Although gastrointestinal endoscopy is an extremely safe and effective means of examining the 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-ray and surgery. Your physician will be happy to discuss these procedures with you if you desire.

**PATIENT PRIVACY**

Our Notice of Privacy Practices is our best effort to assure you that we are serious about protecting your health information. We have placed copies of this document in our waiting area and we encourage you to take one. In this publication we outlined the ways we may use and disclose your protected health information to adequately treat and manage your health care, receive payment for services, and conduct health care operations at this facility. It also outlines your rights regarding your protected health information. If you have specific questions about this document, please let us know.

**YOU MUST ASK YOUR PHYSICIAN IF YOU HAVE ANY QUESTIONS ABOUT YOUR TEST.**

## CONSENT

I understand the above information regarding gastrointestinal endoscopy and/or esophageal dilation, and I have been fully informed of the risks and possible complications thereof; I hereby authorize and permit

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and whomever he/she may designate as his/her assistants to perform upon me the following:

**Esophagogastroduodenoscopy With or Without Dilation with Moderate Sedation (Conscious Sedation).**

including photographing, videotaping, and/or other observation of the procedure for the advancement of medical knowledge and/or education with the understanding that my identity will not be disclosed.

I consent to the administration of medication as deemed necessary by my physician.

I consent to disposal of specimens by the laboratory to which they were sent in accordance with customary practice.

Following the procedure, I agree to have a responsible adult drive me home. I understand that impairment of full mental alertness may persist for several hours following administration of moderate sedation (conscious sedation)

If any unforeseen condition arises during this procedure calling 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, and I acknowledge that no guarantees have been made to me concerning the results of this procedure.

I agree to an observer during my procedure if the situation arises. I also have the right to refuse an observer.

I understand if I present an "Out-of-Hospital Do-Not-Resuscitate Order" (Advance Directive) to the Facility staff, it will not be honored during the entire course of this admission. Written information on Advance Directives and Iowa Endoscopy Center Advance Directive policies have been provided to me.

I confirm that I have read or have had read to me and understand the above information. I have crossed out and initialed any paragraphs above which do not pertain to me.

**DATE:** _____ **TIME:** _____ _____

Signature by patient, parent, or legally authorized person

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Signature of Interpreter (if applicable)

**WITNESS:** _____ **PHYSICIAN:** _____

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