CONSENT FOR UPPER GASTROINTESTINAL ENDOSCOPY AND ANCILLARY PROCEDURES

I have asked my health care team to perform and consent (agree) to have an upper gastrointestinal endoscopy (esophagogastroduodenoscopy or EGD). I also agree to have my health care team perform other procedures or interventions, if advised or found to be of need. These other procedures may include and are not limited to:

- Biopsy/ polypectomy (for the sampling of abnormal tissue or removal of polyps)
- Cautery, metallic clip placement, injection therapy, tattooing (to stop bleeding or to mark an area for locating polyps / lesions in the future)
- Dilatation (stretching narrowed or scarred areas)
- Esophageal banding or sclerotherapy (to stop bleeding from dilated veins)
- Foreign body removal
- Other ____________________________ Patient’s initials: _______

I also consent to being given other medicine and fluids as needed or advised. These may help to provide sedation or keep me hydrated.

The physician performing this procedure is board certified or board eligible by the American Board of Internal Medicine – Gastroenterology. I understand that this procedure will be performed by or under the direction of:

Dr. ___________________________

My physician or my physician’s healthcare team has talked with me about the reasons for the procedure. They also talked about the methods to be used and the purpose. We have also discussed other methods and treatments, if they are available. I understand that for this procedure a small flexible tube with a camera and instruments will be placed in my mouth and advanced into the stomach and upper intestines. I understand that upper endoscopy, not unlike other medical diagnostic tests, cannot completely rule out all disease including ulcers, strictures, polyps and cancer. I also understand that upper endoscopy may not be able to be finished for certain reasons. Some examples include but are not limited to:

- Unusual anatomy
- Retained material in the gastrointestinal tract
- Inability to provide safe or adequate sedation

I was told some possible risks and complications of the procedure. Examples include but are not limited to:

- Aspiration of stomach contents into the lungs
- Bleeding
- Infection
- Ulceration
- Perforation (tearing a hole) of the gastrointestinal tract
- Damage to organs beyond the gastrointestinal tract can also occur
- Dental damage
Even though these risks rarely occur, these complications may include the need for:

- Hospitalization
- Blood transfusions
- Emergency surgery
- Death and/or disability

I understand that sedation and other medicines given during the procedure have a slight risk of unwanted reactions. Some reactions include and are not limited to:

- Allergic reaction
- Vein irritation
- Respiratory and cardiac depression
- Death

I agree that any tissue and body fluids removed, or photos taken during the procedure may be examined, saved or thrown away in any way that is proper for diagnosis and treatment.

I have discussed with my physician or staff the care or assistance I may need once I am discharged.

I have decided to continue with this elective procedure and understand that I may withdraw this consent and decline to have this procedure at any time before I receive any anesthesia.

_____________________________________
Patient Name

_____________________________________
Patient Signature       Date

_____________________________________
Patient / Legal Representative       Date

_____________________________________
Witness       Date

_____________________________________
Physician Signature       Date

_____________________________________
Interpreter (if applicable)       Date