GLST

Gastrointestinal & Liver Specialists of Tidewater, PLLC
Consent for Upper Endoscopy (EGD)

Patient's Name: _____

Procedure Date: _____ Acct#: _____

D.O.B: _____ Performing Dr: _____

Authorization and Nature of this Procedure: I hereby request and authorize Dr. _____ and his/her designated associates/assistants to perform an **upper endoscopy (esophagogastoduodenoscopy/EGD), possible biopsy and possible esophageal dilatation** (widening the esophagus with special plastic tubes or balloon dilators). It has been explained to me that this procedure is an examination of the lining of my esophagus, stomach and a portion of the small intestine by use of a flexible scope, which is passed through the mouth and into the upper digestive tract. During this procedure, biopsies (tissue samples) may be removed. Occasionally when bleeding occurs, cautery may be necessary to stop the bleeding. If my physician identifies a narrowing in my esophagus, it may be dilated by passing soft, sequentially larger diameter instruments through it to stretch the narrowed section.

Risks and Complications: **E**very medical procedure has some degree of risk and the possibility of complications. My physician has explained to me and I understand that complications from this procedure include but are not limited to: bleeding, aspiration of stomach contents into the lungs, perforation or puncture of the wall of the upper GI tract, irregular heart beat, and very rarely, death. **GLST is not liable for any dental damage that may occur.** I am satisfied with the explanation of these possible risks and do not wish to have any further explanation given to me, although I have been advised that I am entitled to do so if I desire. I understand that I may be transferred to another facility in the event that a complication occurs. This decision will be made by my physician or designated health care provider.

Alternative Procedures or Treatment: My doctor has explained to me that alternative procedures are available which also include risks and complications. I am satisfied with my physician's explanation of these options and wish to proceed with an EGD. Such options may include x-rays, barium swallow, CAT scan, or no treatment.

Attendance of other Health Care Providers: I understand that physicians, nurses and assistants may be present to perform and assist with my EGD. I consent to the presence of these health care professionals and **I do____/I do not____** consent to *students/residents/personnel in training* to be present during my procedure.

Photographs: I understand that photographs and/or videotaping may be taken during my procedure for documentation of findings. **I do____/I do not ____** consent to the use of these photographs to be used for teaching purposes. This may include the reproduction of the photographs for publication or to be used in part of a medical education program.

Tissue Disposal: I consent to the appropriate disposal of any body tissues removed during this procedure after the same tissue has been examined by a pathologist.

Anesthesia/Sedation: I consent to the administration of intravenous (IV) medications that will have a sedative effect on me. Possible complications from this may include but are not limited to pain during the administration of medications, soreness/swelling in the arm, cardiac or respiratory arrest, rarely an allergic reaction, which could cause death. I understand that I cannot drive after the procedure until the following morning; I should not sign any legal or important papers or perform tasks that require coordination. I should have a responsible adult with me for the remainder of the procedure day.

No Guarantee or Assurance: I acknowledge that no guarantee or assurance to the outcome of this procedure has been given to me. I do recognize that this is the best test for finding lesions in the upper gastrointestinal tract; however, I understand that this procedure has a low rate of missed lesions/diseases/diagnoses. Recognizing that there may be a failure to diagnose a problem, further testing might be recommended in the future. I know that I must report any persistent or unusual symptoms to my physician to help with detection of lesions or conditions, which might possibly have been missed despite the best clinical performance, by my physician.

No ADVANCE DIRECTIVES: I acknowledge that this facility does NOT recognize advance directives. During my care at this facility, all practical measures will be utilized to prevent loss of life. _____ (Patient initial or signature).

Opportunity for Further Information: I understand that I am free to seek advice from other physicians if I choose. I know that I am also encouraged to ask questions regarding any aspect of this procedure, which I am unclear or unsure of.

Opportunity to Read this Document: I acknowledge by signing this consent that I have read this form in its entirety and fully understand it. I have had my questions answered to my satisfaction and agree and consent to this treatment.

DO NOT SIGN IF YOU HAVE FURTHER QUESTIONS

_____ _____

Signature of Patient or Authorized Person Date

Authorized person's relationship to the patient: _____

_____ _____

Signature of Witness Date

The above procedure(s) have been explained to the patient or authorized person to give consent for the patient.

_____, M.D