Liberty Endoscopy

Patient Information:
Name: _____
Date of Birth: _____
MRN#: _____

CONSENT FOR GASTROINTESTINAL ENDOSCOPY

Informed Consent for Gastrointestinal Endoscopy

Explanation of Procedure

Direct visualization of the digestive tract with lighted instruments is referred to as gastrointestinal endoscopy. Your physician has advised you 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. At the time of your examination, the lining of the digestive tract will be inspected and photographed. If an abnormality is seen or suspected, a small portion of tissue (biopsy) may be removed or the lining may be brushed. These samples are sent for laboratory study to determine if abnormal cells are present. Small growths (polyps), if seen, may be removed. A dye spray or injection may be administered to highlight or demarcate abnormal areas. Various methods may be employed to control bleeding if this is found. Dilation (stretching) may be necessary to open narrowing in the digestive tract. To keep you comfortable during the procedure, an anesthesiologist will administer monitored anesthesia care with medications for comfort and sedation.

Brief Description of Endoscopic Procedures

1. Upper Endoscopy (EGD, or esophagogastroduodenoscopy)/Enteroscopy: Examination of the esophagus, stomach, and/or small intestine with a flexible video/telescope, removal of polyp(s), biopsy or cautery of any suspicious tissue, injection therapy, cautery, or rubber band ligation to control any bleeding sites, possible marking of the intestine to relocate suspicious sites, and dilation (stretching) of narrow areas.
2. Flexible Sigmoidoscopy/Colonoscopy: Examination of the large intestine with the possible removal of polyp(s), possible biopsy or cautery of any suspicious tissue, and/or control of any bleeding site, possible marking of the intestine to relocate suspicious sites, possible dilation of narrow areas, and possible ligation, excision, and/or sclerosis of hemorrhoids.,

Principal Risks and Complications of Gastrointestinal Endoscopy

Gastrointestinal endoscopy is generally a low risk procedure. Your physician has/will discuss their frequency with you, with particular reference to your own indications for gastrointestinal endoscopy. YOU MUST ASK YOUR PHYSICIAN IF YOU HAVE ANY UNANSWERED QUESTIONS ABOUT YOUR TEST. Risks include (but are not limited to):

1. Perforation: Passage of the instrument may result in an injury to the gastrointestinal tract wall with possible leakage of gastrointestinal contents into the body cavity. If this occurs, surgery to close the leak and/or drain the region may be required and/or may necessitate the need for a colostomy.
2. Bleeding: Bleeding (acute or delayed), if it occurs, is usually a complication of biopsy, Polypectomy or dilation. Treatment of this complication may consist of: control of bleeding, careful observation, repeat endoscopy to stop the bleeding, or possibly a surgical intervention and/or blood transfusion.
3. Medication Phlebitis: Medications used for sedation may irritate the vein in which they are injected. This causes a red, painful swelling of the vein and surrounding tissue.
4. Other Risks: Include drug reactions, complications from other diseases you may already have (i.e., colitis or diverticulitis), not being able to complete the exam, and the possibility of missing a polyp or colon cancer.

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Instrument failure and death are extremely rare but remain remote possibilities. YOU MUST INFORM YOUR PHYSICIAN OF ALL YOUR ALLERGIC TENDENCIES AND MEDICAL PROBLEMS.

Alternatives to Gastrointestinal Endoscopy

Although gastrointestinal endoscopy is an extremely safe and effective means of examining the gastrointestinal tract, it is not 100 percent accurate in diagnosis. In a small percentage of cases, a failure of diagnosis or misdiagnosis may result. Other diagnostic or therapeutic procedures, such as virtual colonoscopy, medical treatment, X-ray and surgery are available. Another option is to choose no diagnostic studies and/or treatment. Your physician will be happy to discuss these options with you.

Having read, received, and fully understanding the above information from my physician(s):

I Hereby authorize the following Procedures: _____

1. I have received and fully understand information regarding: (a) the nature and purposes of the proposed Procedure and related care, treatment, services, medications, and interventions; (b) alternatives to the Procedures(s), as well as the relevant risks and benefits of such alternative procedure(s); (c) clinical outcome if I do not elect to have the proposed Procedure(s); (d) the potential benefits and possible risks, side effects and complications associated with the Procedure(s) including any benefits and risks associated with administration of anesthesia (if required) and potential problems that might occur during recuperation; and (e) the likelihood of achieving care, treatment and service goals. I have had the opportunity to ask any questions.
2. I understand the Center's Privacy Notice describes any limitations on the confidentiality of my patient information.
3. I understand that the individuals listed below are the only physicians who are reasonably anticipated to be actively involved in the above listed Procedure.
4. I understand that because of the sedation I may not drive or operate machinery, make critical decisions, sign legal documents or consume alcoholic beverages the day of the procedure.
5. I understand that unforeseen conditions may be revealed that may necessitate a change or extension of the original procedure(s) or a different procedure(s) than those already explained to me. I therefore authorize and request that the physician named below and his/her assistants or designees may perform such procedures as necessary and desirable in the exercise of his/her professional judgment.
6. I authorize the use of services involving pathology and radiology, including the drawing of blood for hepatitis/HIV testing in the event of accidental exposure.
7. I consent to the photographing, filming, or videotaping of the treatment or procedure for diagnostic, documentation or educational use. I understand that my identity will be protected and not disclosed.
8. I agree that any organs or tissues surgically removed may be examined and retained for medical, scientific or educational purposes and such tissues or organs may be disposed of in accordance with customary practices.
9. I consent to the presence of other person(s) for the sole purpose of observation &/or education. I understand this person(s) will not participate in the procedure.
10. 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 result of this procedure.

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11. I hereby authorize and permit the physician listed below and whomever he/she may designate as his/her Assistant/Fellow, to perform the procedure(s) mentioned as outlined above.

Patient Signature _____ **Print Name:** _____

Legally Authorized Representative: _____

Relationship to Patient: _____

Date: _____ **Time**: _____

Witness of Signature Only: _____ **Date**: _____ **Time**: _____

M.D. Signature: _____ **Date**: _____ **Time**: _____

V5/2017