

Informed Consent for Gastrointestinal and Colorectal Procedures

Brief Description of Procedures

1. **Upper Endoscopy (EGD, or esophagogastroduodenoscopy)/Enteroscopy/Ileoscopy/Pouchoscopy:** Examination of the esophagus, stomach, small intestine, ileum, and/or pouch 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.
3. **Anoscopy/High Resolution Anoscopy (HRA):** Examination of the anal canal and rectum with an anoscope to help diagnose anal and rectal conditions with possible biopsy or cautery of any suspicious tissue, and/or control of any bleeding site, possible ligation, excision, and/or sclerosis of hemorrhoids.
4. **Hemorrhoidectomy:** Treatment of hemorrhoids may involve rubber band ligation, application of low thermal energy, or coagulation. The location of the hemorrhoid typically dictates the method of treatment.
5. **Remove of anal papilla or tag:** Treatment of anal papilla or tag may involve cautery or ligation.
6. **Fissurectomy:** Treatment of anal fissures may involve the use of a cautery. Botox injections may also be utilized to eliminate potential sphincter spasms.
7. **Incision and drainage of abscess:** Treatment of abscess involves surgical incision of the affected area to allow drainage and promote healing.
8. **Fistulotomy:** Treatment of anal fistulae involves cutting through the skin and subcutaneous tissue to open the length of the fistula tract and curetting out the fistula lining.

Principal Risks and Complications

Gastrointestinal endoscopies and anoscopies are generally low risk procedures. Your physician has/will discuss their frequency with you, with particular reference to your own indications for the procedure(s). YOU MUST ASK YOUR PHYSICIAN IF YOU HAVE ANY UNANSWERED QUESTIONS ABOUT YOUR PROCEDURE. 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. **Infection:** Infection can occur immediately after the procedure or during the recovery phase and may require treatment with antibiotics or a surgical procedure.
5. **Recurrence of condition:** There is a chance that lesions, papillae or hemorrhoids may recur after treatment.
6. **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. 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

Although these gastrointestinal and colorectal procedures are safe and effective means of examining the gastrointestinal tract, anal canal, and rectum, they are 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),

1. I hereby authorize the following procedure(s) <procedure(s)>
2. 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.
3. I understand the Center's Privacy Notice describes any limitations on the confidentiality of my patient information.
4. I understand that the individuals listed below are the only physicians who are reasonably anticipated to be actively involved in the above listed Procedure.
5. 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.
6. 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.
7. 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.
8. 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.
9. 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.
10. 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.
11. 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.
12. 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

<Patient_Sig>

Print Name:

<patient name>

Legally Authorized Representative:

<Witness1_name>

Relationship to Patient:

<relationship>

Witness of Signature Only:

<Witness2_Sig>

M.D. Signature:

<Physician_Sig>

Today's Date: