

AMBULATORY ENDOSCOPY CENTER OF MARYLAND

Name: _____

Date: _____

Chart #: _____

Informed Consent For Procedures

Direct visualization of the digestive tract and abdominal cavity with lighted instruments is referred to as gastrointestinal endoscopy. Your physician has advised you of your need to understand the reasons for, and possible risks of, these procedures.

At the time of your examination, the inside lining of the digestive tract will be inspected thoroughly and possibly photographed. If an abnormality is seen or suspected, a small portion of tissue (biopsy) may be removed for microscopic study, or the lining may be brushed and washed with a solution that can be sent for analysis of abnormal cells (cytology). Small growths can frequently be completely removed (polypectomy). Occasionally during the examination a narrowed portion (stricture) will be stretched to a more normal size (dilation).

Name of Procedure (*patient is to initial next to checked off boxes*)

_____ [] **Intravenous Sedation:** Conscious sedation, medications are administered through an intravenous (IV) site to make the patient sleepy and more comfortable for the test.

_____ [] **Esophagoduodenoscopy with possible biopsy:** Examination of the esophagus from the throat to the entrance of the small intestine just beyond the stomach (site of most ulcers), frequently done at the same time as esophagoscopy. Biopsy, cytology, specimen collection, and dilation of strictures (below) may be necessary.

_____ [] **Esophageal Dilation:** There are two methods of dilation:

1. **Balloon Dilator:** a flexible catheter with various size balloons is passed through the endoscope. The balloons are inflated in the esophagus and/or pylorus.

2. **Savory Dilator:** a flexible rubber tube that slides over a guide wire (placement of the guidewire into the esophagus is done during upper endoscopy).

_____ [] **Colonoscopy with possible biopsy and/or polypectomy:** Examination of all or a portion of the colon requiring careful preparation with diet, enemas and/or medication. A wire loop or hot biopsy forcep is used to remove all small growths that protrude into the colon. Patients with previous pelvic surgery and those with extensive diverticulosis may be prone to complications.

_____ [] **Percutaneous Liver Biopsy:** Local anesthesia, consisting of an injection of the drug Lidocaine into the skin and deeper tissues over the liver, will be given prior to the performance of the biopsy. Following the administration of the anesthetic, a small cut will be made in the skin and a needle will be passed into the liver to remove a small sample of tissue for examination. It may be possible that more than one attempt may be required to obtain adequate tissue for study.

_____ [] **PEG (Percutaneous Endoscopic Gastrostomy):** By use of an upper endoscope, a small incision is made, under local anesthetic, to place a feeding tube into the stomach. This tube provides a source for the patient to receive nutrients. Infection is a possible risk.

_____ [] **Paracentesis:** Placement of a needle, connected to suction, into the abdomen for removal of fluid from within the abdominal cavity.

_____ [] **Other:** _____

The following has been explained to me in general terms and I understand that:

1. The diagnosis requiring this procedure is _____
2. The nature of the procedure is checked off and initialed by me as indicated on side one.
3. As a result of this procedure being performed, there may be risks or potential complications including: abnormal heart rhythm, trouble breathing, allergic reaction to the sedative medications, bleeding, the possibility of missing a lesion, perforation of the gastrointestinal tract, infection, thrombosed vein or IV infiltration, or death.
4. In addition, with liver biopsies there are additional risks and potential complications including: the risk of perforation of another organ (i.e. gallbladder, lung, bowel, or kidney), bleeding from the biopsy site, pain resulting from the biopsy, or the possibility of not obtaining a specimen.

I certify that I understand the information regarding gastrointestinal endoscopy with or with out intravenous sedation. During this procedure, if I receive conscious sedation, (the risks of which are the same as above in paragraph 3), **I agree not to drive myself home after the procedure and will have a responsible adult drive me or accompany me home after my discharge from the endoscopy center.**

I understand that my physician, medical personnel and other assistants have relied on statements about my medical history and other information in determining the need for this procedure and course of treatment.

I understand that the practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME** concerning the results of this procedure.

I understand that during the course of the procedure described above it may be necessary or appropriate to perform additional procedures, which are unforeseen or not known to be needed at the time this consent is given. I consent to and authorize the persons described therein to make the decisions concerning such procedures. I also consent to and authorize the performance of such additional procedures, as they deem necessary or appropriate.

I consent to diagnosis studies, tests, anesthesia, x-ray examinations and other treatment or courses of treatment relating to the diagnosis or procedures described therein.

I also consent that any tissues or specimens removed from the patient's body in the course of any procedure may be tested or retained for scientific or teaching purposes and then disposed of within the discretion of the physician or pathology lab.

I further consent to the taking and reproduction of any photographs in the course of this procedure for professional purposes.

BY SIGNING THIS FORM I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME, THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ANY QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY. ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ALL STATEMENTS I DO NOT APPROVE OF WERE STRICKEN BEFORE I SIGNED THIS FORM.

I hereby voluntarily request and consent to the performance of the the procedure described or referred to herein by Dr. _____ and any other physicians or other medical personnel who may be involved in the course of my treatment.

Signed: _____ Date and Time: _____

Witness: _____ Physician Signature: _____