

# Informed Consent For Gastrointestinal Procedures

## 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 thoroughly and possibly 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.

## Principal Risks And Complications

Gastrointestinal endoscopy is generally a low risk procedure. However, all of the below complications are possible. Your physician will discuss their frequency with you, if you desire, with particular reference to your own indications for gastrointestinal endoscopy. **YOU MUST ASK YOUR PHYSICIAN IF YOU HAVE ANY UNANSWERED QUESTIONS ABOUT YOUR TEST.**

- PERFORATION:** Passage of the instrument may result in an injury to the gastrointestinal wall with possible leakage of gastrointestinal contents into the body cavity. Perforation would usually, but not always, require surgery.
- BLEEDING:** Bleeding, if it occurs, is usually a complication of biopsy, polypectomy or dilation. Management of this complication may consist only of careful observation, may require transfusions, repeat endoscopy or colonoscopy, or possibly a surgical operation.
- INFECTION AND PHLEBITIS:** Infection or irritation resulting in inflammation (phlebitis) may occur at the intravenous site and may require treatment. Rarely, passage of the endoscope and manipulations may cause infection elsewhere in the body.
- CONSCIOUS SEDATION:** Sedation and analgesia are given to produce "conscious sedation" a state that helps you relax and minimizes unpleasant sensations while maintaining adequate heart and lung function and the ability to respond to verbal stimulation and/or touch. Potential complications of conscious sedation include: breathing problems (decreased respiration, as piration, airway blockage), heart problems (low blood pressure, or irregular rhythm) for which you will be monitored and treated if necessary.
- MISSED LESIONS:** In a small percentage of cases a failure of diagnosis or a mis-diagnosis may result, particularly with colonoscopy. For example, polyps and/or cancerous lesions may be missed, because of the numerous turns and folds in the colon.
- OTHER RISKS:** Include drug reactions and complications from other diseases you may already have. Instrument failure could occur rarely and require a repeat procedure. There is a remote possibility of a heart attack or stroke. A serious complication could result in death or a permanent disability.

## 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. Other diagnostic or therapeutic procedures, such as 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.

## Brief Description Of Endoscopic Procedures

- EGD (Esophagogastroduodenoscopy):** Examination of the esophagus, stomach, and duodenum with a small endoscope. If active bleeding is found, coagulation by heat, banding and/or sclerotherapy may be performed.
- ESOPHAGEAL AND OTHER DILATION:** Dilating tubes or balloons are used to stretch narrow areas of esophagus or GI tract, causing additional risk of perforation of up to 1-2%.
- FLEXIBLE SIGMOIDOSCOPY:** Examination of the anus, rectum and left side of the colon, usually to a depth of 60 cm.
- COLONOSCOPY:** Examination of all or a portion of the colon. Older patients and those with extensive diverticulosis are more prone to complication. Polypectomy (removal of small growths called polyps) is performed, if necessary, by the use of a wire loop and electric current.

The presence of any known **medical allergies**  Not present  Present

If present, please list: \_\_\_\_\_

**My pregnancy status:**  I am pregnant  I am not pregnant  This does not apply

*I consent to the taking and publication of any photographs made during my procedure for use in the advancement of medical education. I certify that I understand the information regarding gastrointestinal endoscopy. I have been fully informed of the risks and possible complications of my procedure. I hereby authorize and permit:*

- |  |  |
|--|--|
| <input type="checkbox"/> T.E. Brown, MD    | <input type="checkbox"/> A.V. Ramakrishnan, MD |
| <input type="checkbox"/> R.M. Williams, MD | <input type="checkbox"/> G. Pandolfi, MD       |
| <input type="checkbox"/> T.J. Attaway, MD  | <input type="checkbox"/> Gilbert K. Ong, MD    |
| <input type="checkbox"/> L.J. Ferrin, MD   |  |

*and whomever he may designate as his assistant to perform upon me the following:*

- |  |                                   |                                      |
|--|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> UPPER ENDOSCOPY | <input type="checkbox"/> DILATION | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> COLONOSCOPY     | <input type="checkbox"/> FLEXSIG  |                                      |

*If any unforeseen condition arises during this procedure calling for (in the physician's judgement) additional procedures, treatments or operations, I authorize him to do whatever he deems advisable. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the result of this procedure.*

*I am aware that in the event of a life-threatening emergency, the Center will perform any necessary emergency procedures and transfer me to an acute care facility.*

DATE \_\_\_\_\_ SIGNED (by patient or legally authorized person) \_\_\_\_\_ TIME \_\_\_\_\_

WITNESS \_\_\_\_\_ DATE \_\_\_\_\_ TIME \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ DATE \_\_\_\_\_ TIME \_\_\_\_\_

- AEC  
 YVMH  
 YRMC

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_