THIS HAS BEEN PROVIDED FOR YOUR REVIEW.
UPON ARRIVAL AT DIGESTIVE HEALTH ENDOSCOPY CENTER, YOU WILL BE ASKED TO SIGN AN ELECTRONIC VERSION OF THIS FORM

INFORMED CONSENT FOR ESOPHAGOGASTRODUODENOSCOPY (EGD)

I authorize Dr._____and any assistant(s) deemed necessary to perform an **ESOPHAGOGASTRODUODENOSCOPY WITH POSSIBLE BIOPSY, POLYPECTOMY AND/OR DILATATION (EGD).**

I understand this procedure allows my doctor to directly look into my digestive tract including my esophagus (swallowing tube), my stomach and the first part of the small intestine (duodenum). If necessary, my doctor may be able to treat and/or take samples or biopsies needed to diagnose and treat my condition.

I understand that **during the procedure** the doctor will use a flexible tube called an endoscope; I will most likely be placed on my left side and under sedation, the doctor will pass the scope through my mouth and into my digestive tract; during this procedure I will be able to still breathe normally. If my doctor sees a narrowed area in my esophagus, it may be stretched (dilated) to a more normal size. Other **benefits of having an EGD** include the ability to get a tissue specimen for biopsy, these tissue samples may be used for more tests and my doctor will let me know if any of the tests results are abnormal. During the EGD my doctor may also be able to determine the reason for other problems such as upper abdominal pain, nausea, vomiting, gastric reflux (heartburn), or problems swallowing.

I understand that according to my condition, I may have **other alternatives** to an EGD including upper GI series, a CT scan or x-rays, these alternatives may be useful and may give general information about problems within the upper digestive tract, but they do not give the in-depth information and direct visibility that an EGD provides.

I understand there may be **risks** associated with any endoscopic procedure. These risks have been explained to me by my doctor and may include but are not limited to: bleeding (immediate or up to 14 days after the procedure), damage to dental work, missed cancer, medication reaction (to sedation or any other medications administered), irritation of the vein used for IV medication, infection, tear or perforation of the intestines, abdominal bloating, and cramping. Rarely, a complication may require additional treatment such as surgery, hospitalization, repeat endoscopy and/or blood transfusion. There is also a small risk of cardiopulmonary events such as loss of breathing and heart rhythm disturbances including rare cardiopulmonary arrest.

I consent to the use of medications administered by a licensed professional to provide me with **sedation.** This is used to relax me and minimize my discomfort during my procedure. I will be monitored throughout the procedure and in the recovery area until ready for discharge. Occasionally under certain circumstances the procedure may be performed without sedation at the discretion of my doctor.

I am advised that if I am a female 50 years and younger, I may be required to submit urine for **pregnancy testing**. I understand that in the event that I refuse the test, the scheduled procedure may be cancelled. I understand that if I am pregnant or if there is any possibility, I may be pregnant, I will

inform the facility immediately since the scheduled procedure and medication administered could cause harm to my child or myself.

In the event that a nurse or physician is/are exposed to my blood or bodily fluids, I give my permission for my blood to be drawn and tested for HIV and Hepatitis to protect me and my caregiver.

I am advised that a responsible adult MUST drive me home and I **MAY** NOT be permitted to ride home alone in a taxi or bus. I have been advised by the facility personnel not to drive or work the day of the procedure. **Should I not have a driver, the procedure could be attempted without sedation or cancelled.**

I understand that, as stated on the **Patients' Rights and Responsibilities form,** if I experience cardiac arrest, respiratory arrest, or any other life-threatening situation while in the facility, I consent for resuscitation and transfer to a higher level of care. At the request of Digestive Health Endoscopy Center, I excuse Digestive Health Endoscopy Center from honoring my previously signed **Advanced Directives** throughout the course of care for this procedure.

By signing below, I confirm that the nature of the **ESOPHAGOGASTRODUODENOSCOPY WITH POSSIBLE BIOPSY, POLYPECTOMY AND/OR DILATATION,** its indications, alternative means of diagnosis or treatment have been explained to me. I have also been informed of the potential risks involved and their possible consequences. I have read this information sheet regarding this procedure and have had the opportunity to discuss the above with my physician and he has answered all my questions to my satisfaction.

If I am not the patient, I represent that I have the authority and full rights of the patient who, because of age or other legal disability, is unable to consent to the matters above.

Patient or Person Authorized to sign for patient	Date (and relationship if other than patient)
Witness to Signature	Date

I certify that I have explained the nature, purpose, benefits, risks, complications, and alternatives to the proposed procedure to the patient and/or their legal representative. I have given them the opportunity to ask questions and all questions have been answered. The patient and/or legal representative has expressed understanding of what I have explained and agrees to the procedure.

Physician signature	Date