

ENDOSCOPY INFORMATION AND CONSENT FORM

Direct visualization of the upper digestive tract with a lighted instrument is referred to as an upper endoscopy. Your physician, _____, M.D., has advised you of the need to have this type of examination. The following information is presented to explain the procedure and review the possible risks of the procedure.

After you complete a preparation that may include no solid foods, you will be placed on your left side on the examining table. An IV will be started and intravenous sedation will be given. A flexible lighted tube (endoscope) will be inserted through the mouth and back of the throat and the inside lining of your esophagus, stomach, and duodenum will be carefully inspected. A small piece of tissue (a "biopsy") may be removed for examination under the microscope. Growths ("polyps") that may develop in the digestive tract will be removed using forceps or electrocautery. Electrocautery may also be used to coagulate any bleeding lesions. If there is a narrowed area in the G.I. tract, it may need to be dilated.

Following sedation, your judgment, perception and coordination are considered impaired. You must, therefore, have someone drive you home as you cannot drive for at least 12 hours following you procedure.

Minor side-effects include pain or redness at the IV site, gas or bloating, nausea, vomiting, or drowsiness after the procedure. Rarely, discomfort may be felt in the abdomen or rectum. These sensations pass and are of a minor nature.

The following are rare risks of these procedures, but could be potentially life-threatening:

1. Injury to the lining of the digestive tract resulting in perforation of the esophagus and leakage into body cavities. If this occurs, surgical operation to close the leak and drain the region may be necessary.
2. Bleeding, if it occurs, usually is a complication of biopsy, polyp removal (polypectomy), dilation or electrocoagulation. Management of this complication may consist only of careful observation or may require hospitalization, transfusion, or rarely surgical operation for control.
3. Heart or lung complications.
4. Adverse reaction to medications.
5. Missed cancer.

Preparation instructions have been reviewed in detail with me and I am in receipt of these instructions.

I certify that I have read the above and understand the possible risks and complications noted. The doctor has also discussed the possible alternative examinations with me. I consent to the taking of photographs of my intestinal tract for my record. I hereby authorize and permit _____, M.D., and whomever he/she may designate as assistants to perform the following procedure: **UPPER ENDOSCOPY w/ possible biopsy, polypectomy, or cauterization.**

Signature of Patient

Date

Signature of Witness

Date