

EASTSIDE ENDOSCOPY CENTER

INFORMED CONSENT FOR GASTROINTESTINAL ENDOSCOPY

It is very important to your doctor that you understand and consent to the treatment your doctor is rendering and any treatment your doctor may perform. You should be involved in any and all decisions concerning the procedures which you may need to have. Sign this form only after you understand the procedure, the risks, the alternatives, the risks associated with the alternatives and all of your questions have been answered. Please initial and date directly below this paragraph indicating your understanding of this paragraph.



Patient's Signature or Authorized Individual

Date

I hereby authorize and permit:

<input type="checkbox"/> Raj Butani, M.D.	<input type="checkbox"/> Kalle Kang, M.D.	<input type="checkbox"/> Sang Kim, M.D.	<input type="checkbox"/> Edwin Lai, M.D.
<input type="checkbox"/> Venkatachala Mohan, M.D.	<input type="checkbox"/> Carol Murakami, M.D.	<input type="checkbox"/> Georgia Rees-Lui, M.D.	<input type="checkbox"/> Roanne Selinger, M.D.
<input type="checkbox"/> Stuart Triester, M.D.	<input type="checkbox"/> Shie-Pon Tzung, M.D.	<input type="checkbox"/> George Winters III, M.D.	<input type="checkbox"/> Robert Wohlman, M.D.

and any associates or assistants the doctor deems appropriate, to perform upon me the following:

<input type="checkbox"/> Upper Endoscopy (EGD) with possible dilation	<input type="checkbox"/> Flexible Sigmoidoscopy	<input type="checkbox"/> Enteroscopy
<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Variceal Banding	<input type="checkbox"/> EIS (Injection Sclerotherapy)
<input type="checkbox"/> Other _____		

The doctor has explained the benefits of gastrointestinal endoscopy to me. However, I understand there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of the procedure(s). I am aware that the practice of medicine and surgery are not an exact science. I also authorize the administration of sedation and/or anesthesia as may be deemed advisable or necessary for my comfort, well being, and safety. I have been informed by my physician and the staff of the Eastside Endoscopy Center that if I receive sedation, I should not operate a motor vehicle for twelve hours following the procedure.

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 also be removed.

Brief Description of Endoscopic Procedures


- EGD (Esophagogastroduodenoscopy):** Examination of the esophagus, stomach, and duodenum. If active bleeding is found, coagulation by heat may be performed.
- Esophageal Dilation:** Dilating tubes or balloons are used to stretch narrow areas of the esophagus.
- EIS (Endoscopic Injection Sclerotherapy):** Injection of a chemical into varices (dilated varicose veins of the esophagus) to sclerose (harden) the veins to prevent further bleeding. Injection is done with a small needle probe through the endoscope.
- Variceal Banding:** The physician places a latex (rubber) band around the varices to reduce the flow of blood to the vein, thereby preventing further bleeding.
- 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. The procedure may involve collection of a specimen.
- Enteroscopy:** Small intestinal Endoscopy beyond the second portion of the duodenum and not including the ileum. The procedure may involve collection of a specimen.
- Polypectomy:** Using a wire loop and electric current, polyps (protruding growths) can be removed from the digestive tract; commonly done with colonoscopy and less commonly with EGD.
- Conscious sedation:** Administration of IV medications prior to the procedure to achieve a state of relaxation sufficient to improve tolerance for the procedure but not result in significant depression of breathing or total inability to respond.

Principal Risks and Complications.


The doctor has explained to me that there are risks and possible undesirable consequences associated with any procedure *including, but 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 is usually required.
2. **Bleeding:** Bleeding, if it occurs, is usually a complication of biopsy, polypectomy or dilation. Management of this complication may consist only of careful observation, or may require transfusions or a surgical operation.
3. **Conscious Sedation Medication and Pregnancy:** I understand that to keep me comfortable during the procedure, either my doctor or a Registered Nurse directed by my doctor will administer medication defined as Conscious Sedation.

- I understand that there are risks involved with anesthesia and to my knowledge, I am not pregnant.

 _____
Patient initials

- If there is any question that I may be pregnant, then I will allow a urine pregnancy test to be performed prior to my procedure.

 _____
Patient initials

4. **Medication Phlebitis:** Medications used for sedation may irritate the vein into which they are injected. The irritation may result in a red, painful swelling of the vein and surrounding tissue that can become infected. Discomfort may persist for several weeks or months.
5. **Missed Lesions (Polyps and Cancer):** During your colonoscopy the physician will attempt to identify all polyps and cancer, and remove all polyps if possible. Although colonoscopy is the best test to find and remove these lesions, there is a small chance that one or more may be missed.
6. **Splenic Tear:** As the scope passes through the splenic flexure in the colon, there is the rare possibility that an injury can occur to a patient's spleen. A splenic tear is an abrasion on the spleen that could result in hospitalization, the need for blood transfusion, and may even require surgery to treat.
7. **Other Risks** include, but are not limited to respiratory problems, decrease in blood pressure, allergic reaction, slurred speech, unaroused sleep, impaired cardiovascular function, aspiration and pneumonia, heart attack, damage to teeth or dental work (when instruments are inserted through the mouth), collapsed lung when visualizing the respiratory tract as well as nose and throat pain (a special tube may be placed into the chest to re-expand the lung when this occurs), clotting or infection in the vein where medication is given, and very rarely, death. Instrument failure is also extremely rare but remains a remote possibility. Drug reactions and complications from other diseases are possible.

YOU MUST INFORM YOUR PHYSICIAN OF ALL YOUR ALLERGIC TENDENCIES AND MEDICAL PROBLEMS.

In addition, older patients and those with extensive diverticulitis are more prone to complications.

All of the above complications are possible but occur with a very low frequency. Occasionally one or more of these complications could result in transfer to the hospital for hospitalization, blood transfusion, or the need for surgical intervention for correction. Your physician will discuss the frequency of these complications if you desire in reference to your own indications for the endoscopy.

In permitting my doctor to perform gastrointestinal endoscopy, I understand that unforeseen conditions may be revealed that may necessitate 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 above-named physician, his assistants, or his designees perform such procedure(s) as necessary and desirable in the exercise of his/her professional judgment. I understand the Endoscopy Center **does not recognize Do Not Resuscitate** orders and will use all measures possible to sustain life.

Alternatives

The reasonable alternative(s) to gastrointestinal endoscopy, as well as the risks to the alternatives, have been explained to me. The alternatives include **but are not limited to** the following. Although gastrointestinal endoscopy is a safe and effective means of examining the gastrointestinal tract, it is not 100 percent accurate in diagnosis. In a small percentage of cases a failure of diagnosis or a misdiagnosis may result. 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.

I hereby authorize the doctor to dispose of any removed tissues resulting from the procedure(s) authorized above.

I consent to the taking and publication of photographs or videotapes of the procedure(s) made during my procedure for use in the advancement of medical education, provided my identity is not revealed by the pictures or by descriptive text accompanying them.

Any questions I had regarding gastrointestinal endoscopy that apply to my clinical circumstances have been answered to my satisfaction. The advantages and disadvantages of the endoscopy center versus the hospital setting have been discussed with me.



Date Time Signature of Patient or Authorized Individual Relationship of Authorized Individual

- WITNESS: The Patient/Authorized Individual has read the forms or had it read to him or her.
 The Patient/Authorized Individual expresses understanding of the form.
 The Patient/Authorized Individual has no questions.

Date Time Signature of Witness

CERTIFICATION OF PHYSICIAN

I hereby certify that I have discussed and explained the facts, risks, the risks associated with the alternatives of the procedure(s) described in this Consent form with the individual granting consent.

Date Time Signature of Physician

_____ An interpreter or special assistance was used to assist patient in completing this form as follows:

_____ Foreign language (specify)

_____ Sign language

_____ Patient is blind, form read to patient

_____ Other (specify) _____

Interpretation provided by _____
(Fill in name of Interpreter and Title or Relationship to Patient)

Signature (Individual Providing Assistance) Date Time