THE CENTER FOR Digestive Wellness TRICITIES Gastroenterology

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# CONSENT FOR ESOPHAGOGASTRODUODENOSCOPY (EGD)

I permit Dr. _____ and such other or persons as are needed to assist him to perform the following procedure on me:

**EGD (Esophagogastroduodenoscopy) and possible biopsy, polypectomy, dilation or hemostasis.** After medicines are given into a blood vessel to relax me, a long flexible tube (gastroscope) is passed through the mouth and back of the throat to allow the physician to examine the lining of the esophagus, stomach and small intestine. If the doctor sees a suspicious area, he can pass an instrument through the endoscope and take a small piece of tissue (biopsy) for examination. If the doctor feels the removal of a growth (polyp) is indicated, he will pass a wire loop (snare) through the endoscope and sever the attachment of the polyp from the wall by means of an electrical current. If the doctor finds a narrowing (stricture), he may attempt to dilate (stretch) it with special tubes or plastic balloon. If the doctor sees an area, which he believes needs to be treated for bleeding, he may pass a special device through the endoscope to clot it with heat or inject it with a chemical.

**ALTERNATIVES:** Possible alternatives vary for each patient as some alternatives may be inappropriate for a number of reasons. However, these potential alternatives include x-rays, surgery, no examination or other possible alternatives that have been explained to me.

**POSSIBLE RISKS AND COMPLICATIONS:** (1) Anesthesia medications can cause a slowing or stopping of breathing, which can usually be reversed with other medications. (2) In patients with abnormal or replaced heart valves, artificial joints or vascular surgery grafts, there is a chance of infection if dilation is performed. (3) Injury to the lining of the intestinal tract may result in a hole (perforation) of the wall. (4) Bleeding, if it occurs, is usually a complication of biopsy, polypectomy or dilation. (5) Irregular heartbeat or pneumonia. (6) Irritation in the vein that was used for administration of medication. (7) Sore throat. Other risks include drug reactions and complications incident to other diseases you may have. Blood transfusion or surgery may be necessary because of complications. The risk of serious complication is 1 in 1000. If any unforeseen condition arises during this procedure, calling on his judgment for additional procedures, operations or medications (including anesthesia and blood transfusions), I further request and authorize him to do whatever he deems advisable.

I know the doctor can not tell me about every possible risk, alternative, complication or side effect, but I understand that we discussed the major ones. I am also aware that the practice of medicine is not an exact science. It is possible an abnormality, even if present, will go undetected. The result of this missed diagnosis is unknown. I acknowledge that no guarantees have been made to me concerning the results of this procedure.

Any tissue removed will be disposed of by the designated laboratory in accordance with the accustomed practice. I consent to the taking and publication of any photographs in the course of this procedure for the purposes of documentation and medical education. I consent to the participation of medical students, nurses, and residents during my procedure, who are under the direct supervision of my physician.

In the event that a nurse or physician should be exposed to my blood through needle stick or other unforeseen incident, I hereby give my permission for my blood to be drawn and tested for HIV, or any other blood borne pathogen that the physician deems necessary to adequately protect me and my care giver.

The Center for Digestive Wellness is solely owned and operated by Jeffrey P. Fenyves, M.D. and Stephen W. Fry, M.D., and used exclusively for patients of Tri-Cities Gastroenterology.

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**Do you have a living will or durable power of attorney (advance directive)? ___ yes ___ no.**
In the ambulatory setting, if a patient should suffer a cardiac or respiratory arrest of other life-threatening situation, the signed consent implies consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with Federal and State law, the facility is notifying you we will not honor previously signed advance directives for any patient.
If you should be transferred to another health care facility upon leaving our Center, your advance directive will be honored according to the policy of that facility.

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My doctor and I have discussed the proposed procedure, its alternatives, possible risks, complications and side effects. I am willing to accept these risks.

I read this form or had it read to me. I understand what the form says and I do not have any unanswered questions.

**Signed:** _____ **Date:** _____
(By patient or legally authorized to consent for the patient)
**Name:** _____ **Relationship to Patient:** _____

**Witnessed by:** _____
NOTE: This facility, or physicians, and employees will not be responsible for any personal items lost during your visit here for your procedure or treatment (jewelry, dentures, glasses, contact lenses, hearing aids, purses, clothing, etc.)