BRONSON	Affix Patient Label
	Patient Name: DOB:

Informed Consent Percutaneous Gastrostomy Tube Placement

This information is given to you so that you can make an informed decision about having: **Percutaneous Gastrostomy Tube Placement**

The provider will use ultrasound and X-ray to guide placement of the gastrostomy tube. If you do not have one in place, a tube will be placed into your nose. This tube will be used to fill your stomach with air. It allows the provider see the stomach more clearly while using X-ray. A small incision is made into your stomach and a wire is placed into it. A tube is passed over the wire and the wire is removed, leaving the tube in place. The placement of the tube is checked by injecting x-ray dye. This is to make sure it is in the right place. The tube is held in place with stitches. An internal balloon is inflated to keep the tube in place.

Local anesthetic will be used at the tube placement site. You will be given some intravenous relaxing and pain medicines to keep you comfortable. For most patients, the procedure is well tolerated. Some patients will have moderate discomfort. This is usually well controlled with the relaxing and pain medicine. If general anesthesia or stronger sedation is needed, your provider will discuss this with you.

Reason and Purpose of the Procedure:

Percutaneous gastrostomy is a procedure for placing a tube into your stomach. It is for feeding or giving medicine. It is used in patients who are not able to take food or medicine by mouth for a long period of time.

Benefits of this procedure:

You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- A safe method for getting nutrition and medicine.
- Release of pressure from the small bowel and stomach.

Risks of procedure:

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

General risks of Procedure:

- Bleeding may occur. If bleeding is excessive, you may need a transfusion or other procedures.

Risks of this Procedure:

- Risk of infection at the insertion site. This may require more treatment, including antibiotics.
- Tube dislodgement, blockage, or rupture. This may require a repeat procedure to replace the tube.
- Gastrointestinal tear. This may require surgery.
- Injury to stomach and/or surrounding organs. This may require surgery.

Risks associated with smoking:

Smoking is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks associated with obesity:

Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks specific to you:

_____

_____

_____

_____

Alternative Treatments:

Other choices:

- Surgery may be an option.
- Do nothing. You can decide not to have the procedure

If you choose not to have this treatment:

- Your ability to eat, drink, and take medicines actions could be negatively affected.

General Information

During this procedure, the doctor may need to perform more or different procedures than I agreed to.

During the procedure the doctor may need to do more tests or treatment.

Tissues or organs taken from the body may be tested. They may be kept for research or teaching. I agree the hospital may discard these in a proper way.

Students, technical sales people and other staff may be present during the procedure. My doctor will supervise them.

Pictures and videos may be done during the procedure. These may be added to my medical record. These may be published for teaching purposes. My identity will be protected.

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By signing this form I agree:

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with the doctor. My questions have been answered.
- I want to have this procedure: **Percutaneous Gastrostomy Tube Placement**
- I understand that my doctor may ask a partner to do the biopsy.
- I understand that other doctors, including medical residents or other staff may help with biopsy. The tasks will be based on their skill level. My doctor will supervise them.

Provider: This patient may require a type and screen or type and cross prior to surgery. If so, please obtain consent for blood/products.

Patient Signature_____Date:_____Time:_____

Relationship: □Patient/Parent of minor □Closest relative (relationship) □Guardian

Interpreter's Statement: I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.

Interpreter: _____Date_____Time_____

Interpreter (if applicable)

For Provider Use ONLY:

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention. I have answered questions, and the patient has agreed to procedure.

Provider Signature: _____ Date: _____ Time: _____

Teach Back

Patient shows understanding by stating in his or her own words:

____ Reason(s) for the treatment/procedure: _____

____ Area(s) of the body that will be affected: _____

____ Benefit(s) of the procedure: _____

____ Risk(s) of the procedure: _____

____ Alternative(s) to the procedure: _____

OR

____ Patient elects not to proceed: _____ Date: _____ Time: _____

(Patient signature)

Validated/Witness: _____ Date: _____ Time: _____