BRONSON	Affix Patient Label
	Patient Name: DOB:

Informed Consent Esophageal Dilatation with Biopsies

This information is given to you so that you can make an informed decision about your child having an **Esophageal Dilatation with Biopsies**

Reason and Purpose of the Procedure:
An **Esophageal Dilatation with Biopsies** is a procedure that widens a part of the esophagus that is too narrow. The esophagus is the tube that carries food from the mouth to the stomach. Food and liquids may have a hard time passing through that area. Making that area wider will help relieve problems with swallowing food and liquids. This procedure may have to be repeated in the future.

Benefits of this Surgery:
Your child's doctor cannot promise your child will receive any of this benefit. Only you can decide if the benefits are worth the risk.

Your child may receive the following benefits. **An Esophageal Dilatation will:**
- Open up narrow areas in the esophagus. This will make it easier for your child to swallow food and drinks.

Risks of Surgery:
No procedure is completely risk free. Some risks are well known. Some of these risks can happen even when all steps are taken to prevent them. There may be risks not included in the list that your child's doctor cannot expect.
- Pain or discomfort. This may require medicine to treat the pain.
- Infection. This may require the use of medicine.
- Perforation or tear. This may require a stay in the hospital for other treatments.
- Bleeding. Sometimes it may need a transfusion.

Risks Specific to your child:

_____

_____

_____

Alternative Treatments:
Other choices:
- You can decide not to let your child have this procedure.

If you choose not to have this treatment for your child:
- Swallowing may get worse or impossible
- Food may get stuck in the esophagus. This will require an emergency procedure.

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 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 my child to have this procedure: **Esophageal Dilatation with Biopsies**
- I understand that my doctor may ask another doctor with the same qualifications to do this surgery/procedure.
- I understand that other doctors, including medical residents or other staff may help with surgery. 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/product.

Parent/Guardian Signature_____Date:_____Time:_____

Relationship: □Patient □Closest relative (relationship)_____ □Parent/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 patient has agreed to procedure.

Provider signature:_____ Date:_____ Time:_____

Teach Back

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 parent has agreed to procedure.

Parent 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

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

(parent signature)

Validated/Witness:_____ Date:_____Time:_____