



Affix Patient Label

Patient Name:

Date of Birth:

Informed Consent For Pediatric Esophagoduodenoscopy (EGD) with Biopsies

This information is given to you so that you can make an informed decision about your child having an **Esophagoduodenoscopy (EGD) with Biopsies**.

Reason and Purpose of the Procedure:

EGD is a procedure that allows the doctor to look at the lining of the esophagus (the tube that connects your throat to your stomach), stomach, and the first part of the small intestine. It is done with a small flexible camera that is inserted into the back of the throat. It also lets the doctor biopsy (take a piece of tissue) areas that are of concern. This is sent to pathology to review.

Benefits of this Procedure:

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

- Helps the doctor to diagnose specific medical conditions so treatment can be started.
- Allows the doctor to take small pieces of tissue. These are sent to the pathologist to review.
- Allows the doctor to treat serious conditions such as bleeding, or dilating (expanding) narrowed areas. This can prevent the situation from becoming life threatening.

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.

Risks of this Procedure:

- **Infection.** Your child may need antibiotics.
- **Perforation.** This is a small hole or puncture. This can occur in the esophagus, stomach, or duodenum. Your child may need surgery to repair.

Information on Moderate Sedation:

Your child will be given medicine in an IV to relax him/her. This medicine will also make your child more comfortable. This is called “moderate sedation”. Your child will feel sleepy. He/she may sleep through parts of the procedure. We will monitor your child’s heart rate and blood pressure. We will also monitor their oxygen level. If your child’s heart rate, blood pressure or oxygen levels fall outside the normal range, we may give medications to reverse the sedation. We may not be able to reverse the sedation. We may need to support their breathing. Even if your child has a NO CODE status, they

- may need intubation to support their breathing.
- may need medications to support their blood pressure.

We will re-evaluate your child’s medical treatment plan and NO CODE status when sedation has cleared their body.



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General Risks of Procedure:

- Small areas of the lungs may collapse. This would increase the risk of infection. This may need antibiotics and breathing treatments.
- Clots may form in the legs, with pain and swelling. These are called DVTs or deep vein thrombosis. Rarely, part of the clot may break off and go to the lungs. This can be fatal.
- Bleeding. If excessive bleeding, your child may need a blood transfusion.
- Reaction to the anesthetic may occur. The most common reactions are nausea and vomiting. In rare cases, death may occur. The anesthesiologist or doctor will discuss.

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 Your Child:

Alternative Treatments:

Other choices:

- Medication.
- Diet changes.
- Do nothing. You can decide not to have your child have the procedure.

If You Choose Not to Have this Treatment:

- Medical condition may get worse.

General Information:

- During this procedure your child’s doctor may need to perform more or different procedures that I agree to.
- During the procedure your child’s 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. Your child’s doctor will supervise them.
- Pictures and videos may be done during the procedure. These may be added to your child’s medical record. These may be published for teaching purposes. My child’s 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 my child’s doctor. My questions have been answered.
 - I want my child to have this procedure **Esophogastroduodenoscopy with biopsies:**
-
- I understand that my child’s doctor may ask a partner to do the surgery.
 - 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 child’s 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 Signature _____ Date: _____ Time: _____

Relationship: Parent 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 parent has agreed to procedure.

Provider signature: _____ Date: _____ Time: _____

Teach Back

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: _____ (parent signature)

Validated/Witness: _____ Date: _____ Time: _____