



Affix Patient Label

Patient Name:

Date of Birth:

Informed Consent: Esophagogastroduodenoscopy and Colonoscopy

This information is given to you so that you can make an informed decision about having an **Esophagogastroduodenoscopy and Colonoscopy**.

Reason and Purpose of this Procedure:

Esophagogastroduodenoscopy is sometimes called an **EGD**. It is also called an upper endoscopy or gastroscopy. An EGD is a procedure that is done so that the doctor can look inside your esophagus (the tube connecting your mouth and stomach), stomach and upper duodenum (the beginning of your small intestine). This is done to help the doctor find out what may be causing your symptoms.

Your doctor will insert a thin, flexible tube with a camera on the end (an endoscope) through your mouth. It will be guided through the throat, and into the esophagus, stomach, and duodenum. The doctor will be able to see the pictures on a video screen. A small sample of tissue (biopsy) may be taken. Pictures may be taken.

If your doctor finds specific problems during the procedure, he/she may also perform other treatments. This may include the removal of foreign objects or dilatation (opening up) of your esophagus.

You will be given some medicine to help you relax and pain medicine during the procedure.

A colonoscopy is an internal examination of your colon (large intestine) and rectum using a thin, flexible tube with a camera on the end (a colonoscope). This is done to help the physician find out what may be causing your symptoms.

Your doctor will insert a colonoscope gently through your anus. The scope is then moved into the beginning of the large intestine. A small sample of tissue (biopsy) may be taken. Small growths called polyps may be removed during the procedure. Pictures may be taken. The doctor will be able to see the pictures on a video screen.

You will be given some medicine to help you relax and pain medicine during the procedure.

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.

- Your doctor may be able to diagnose and treat a specific condition.
- Early detection of cancer.
- Relief of narrowing of the esophagus.

Risks of this 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.

- **A tear in the stomach, duodenum, esophagus, or large intestine.** This may require additional treatment and/or surgery to correct.
- **Bleeding.** This may need further treatment or repair.
- **Splenic laceration.** This may require further treatment or surgical repair.
- Nausea, vomiting, bloating or rectal irritation caused by medications taken to cleanse the bowel. These are temporary.
- **Complications from sedation medicine.** These include low blood pressure and breathing problems including slow breathing and aspiration (choking on vomit). A reaction to the medication can cause throat spasms, and excessive sweating. You will be watched by a nurse and given oxygen to breathe.

- Infection that may require antibiotics.
- **Injury to your teeth, lips, or throat.** This is rare.

Rare Risks of Polyp Removal:

- Infection at the removal site with possible abscess.
- Gas or air trapped under the skin.
- Entrapment of normal bowel in the tool (snare) used to grab and cut the polyp.

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:

- Your physician can discuss any other treatments for your particular symptoms.
- Do nothing. You can decide not to have the procedure.

If you Choose not to have this Treatment:

- Your symptoms may not be diagnosed or treated.
- If you have bleeding, cancer, or any other undiagnosed problem, it may lead to death.

Information on Moderate Sedation:

You will be given medicine in an IV to relax you. This medicine will also make you more comfortable. This is called “moderate sedation”. You will feel sleepy. You may even sleep through parts of your procedure. We will monitor your heart rate and your blood pressure. We will also monitor your oxygen level.

If your heart rate, blood pressure or oxygen levels fall outside the normal range, we may give medications to reverse the sedation. We may be unable to reverse the sedation. We may need to support your breathing.

Even if you have a NO CODE status:

- You may need intubation to support your breathing.
- You may need medications to support your blood pressure.

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

Benefits of Moderate Sedation:

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.

- Less pain during the procedure.
- Less anxiety or worry.
- Decreasing your memory of the procedure.

Risks of Moderate Sedation:

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. The list includes:

- Decreased breathing during the procedure and dropping oxygen levels. To help you breathe, a tube may be placed into the mouth or nose and into the trachea to help you breathe.
- Allergic reactions: nausea & vomiting, swelling, rash.
- Vomit material getting into the lungs.
- A drop in blood pressure. This needs fluids or medicine to increase blood pressure.
- Heart rhythm changes that may require medicines to treat.
- Not enough sedation or analgesia resulting in pain or discomfort.

Your physical and mental ability may not be back to normal right away. You should not drive or make important decisions for at least 24 hours after the 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 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 salespeople, and other staff may be present during the procedure. My doctor will supervise them.

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

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: **Esophagogastroduodenoscopy and Colonoscopy**_____
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- I understand that my doctor may ask a partner to do the procedure.
 - I understand that other doctors, including medical residents or other staff may help with the procedure. 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 procedure. If so, please obtain consent for blood/products.

Patient Signature: _____ Date: _____ Time: _____

Relationship: Patient Closest relative (relationship) _____ Guardian/POA Healthcare

Reason patient is unable to sign: _____ Telephone Consent Obtained

First Witness Signature: _____ Second Witness Signature: _____ Date: _____ Time: _____
(One witness signature MUST be from a registered nurse (RN) or provider)

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

Interpreter's Signature: _____ ID #: _____ Date: _____ Time: _____

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:
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: _____