	Affix Patient Label
	Patient Name: DOB:

Informed Consent Radiology Guided Gastric Tube Check with Possible Change or Removal

This information is given to you so that you can make an informed decision about having **Radiology Guided Gastric Tube Check with Possible Change or Removal.**

Reason and Purpose of the Procedure:

A **tube check** is done by injecting x-ray dye into the tube. Then an x-ray is taken. This allows the radiologist to see the placement and function of your tube.

A **tube change** is done by passing a wire through the tube. The tube is taken out over the wire and replaced with another tube. The procedure is guided by x-ray. After the new tube is put in place, the wire is removed. The position of the tube is checked by the injection of x-ray dye.

Local anesthetic may be injected at the tube site and you may be given some intravenous relaxing medication and pain medicine during the procedure. For most patients, the procedure is well tolerated. Some patients will have moderate discomfort. This is usually well controlled with the intravenous relaxing and pain medication. If general anesthesia or stronger sedation is needed, your doctor will discuss that with you.

The tube check with possible change or removal is to check the function of your tube and to replace the tube if necessary.

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.

- Continued use of your tube for nutrition and medication

Risks of Surgery:

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 surgery:

- Bleeding may occur. If bleeding is excessive, you may need a transfusion.
- Reaction to the anesthetic may occur. The most common reactions are nausea and vomiting. In rare cases, death may occur. The anesthesiologist will discuss this with you.

Risks of this surgery:

- Risk of infection at insertion site; this may require further treatment, including antibiotics.
- Tube dislodgement, blockage, or rupture; this may require a repeat procedure to replace the tube.
- Gastrointestinal tear; this may require urgent 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 medications could be adversely 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.

BRONSON

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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: **Radiology Guided Tube Check with Possible Change or Removal**
- I understand that my doctor may ask a partner to do the surgery.
- 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: ________