RWJ UNIVERSITY HOSPITAL SOMERSET

Place patient ID sticker here.

GI Center – Informed Consent for EGD / Colonoscopy

Direct visualization of the digestive tract and abdominal cavity with lighted instruments is referred to a gastrointestinal endoscopy. Your physician has explained why this type of examination is recommended. The following information is provided to help you understand the reasons for, and possible risks of, these procedures.

At the time of your examination, the inside lining of the digestive tract will be inspected thoroughly and possibly photographed. If an abnormality is seen or suspected, a small portion of tissues (biopsy) may be removed for microscopic study, or the lining may be brushed and washed with a solution to be sent for special study for abnormal cells (cytology). Small growths can frequently be removed (polypectomy). Occasionally during the examination, a narrowed portion of intestine (stricture) will be stretched to a more normal size (dilatation).

The principal risks of these procedures are:

1. Injury to the intestine by the instrument, which may result in perforation of the bowel wall with leakage of intestinal juices into body cavities; if this occurs, surgery to close the leak and/or drain the region is usually necessary.
2. Bleeding, which if it occurs, is usually a complication of biopsy, polypectomy or dilatation. Management of this complication may consist of careful observation only or may require a blood transfusion or a surgical operation for control.
3. Failure to visualize a significant abnormality of the digestive tract examined with the endoscope.

   I am aware that, as a result of my condition, the transfusion of blood products is or may become necessary. The reasonable benefits and some of the potential risks of this treatment have been explained to me. While the precautions taken by my physician and the testing and screening of donors and their blood products generally prevent complications of transfusion, I understand that I may still be subject to ill effects as a result of receiving blood products, such as rash, hives, chills, fever, nausea, allergic reactions, transmission of diseases such as Hepatitis, AIDS and other diseases, known and unknown, fluid overload, anaphylactic shock and death.

   Other risks include drug reactions and complications from other associated diseases, which you may have such as a stroke or heart condition. You should inform your physician of all your allergic tendencies and medical problems.

All of the above complications are possible, but rarely occur. Your physician will discuss the frequency of complications with you, if you wish, with a particular reference to your own indications for gastrointestinal endoscopy.

A brief description of each endoscopic procedure follows:

1. **Esophagoscopy** – Examination of the esophagus from the throat to the entrance of the stomach. Biopsy, cytology specimen collection and dilatation of strictures may be necessary.
2. **Gastroscopy** – Examination of the stomach pouch, usually combined with esophagoscopy and/or duodenoscopy.
3. **Duodenoscopy** – Examination of the small intestine just beyond the stomach (site of most ulcers) and frequently done at the same time as esophagoscopy and gastroscopy.
4. **Coagulation** – Process of using electrocautery, laser or heater probe to control bleeding.
5. **Hemostatic Therapy** – Injection of sclerosing solution or placement of rubber bands.
6. **Duodenoscopy with endoscopic retrograde cannulation of common bile and pancreatic ducts (ERCP)** – Examination of duodenum with the placement of a small tube through the instruments into the duct entrances in the duodenum, allowing injection of dye and x-ray examination of an otherwise frequently inaccessible area. Inflammation of the pancreas and infection area additional recognized risks.
7. **a) Ridid Ano-Procto-Sigmoidoscopy** – Examination of the anus, rectum and lower colon (large intestine).

   b) Flexible Sigmoidoscopy (Partial Colonoscopy) – Examination of a portion of the lower colon with flexible instrument.
8. **Coloscopy (Colonoscopy)** – Examination of all or portion of the colon requiring careful preparation with diet, enemas and medication. Older patients, those with previous surgery and those with extensive diverticulosis, possibly are more prone to complications.

9. **Colonoscopy with polypectomy** – Performed as in # 6 above using a wire loop and electric current to remove small growths, which protrude into the colon.
10. **Endoscopic ultrasound** – Examination of the gastrointestinal tract with a scope tipped with an ultrasound sensor.

I understand that during the course of the procedure color photographs may be taken of my gastrointestinal tract and maintained as part of the Medical Center or physician's confidential record.

The administration of medications (**IV Conscious Sedation**) to dull or reduce the intensity of pain and awareness of procedure(s) may be deemed necessary or advisable in the judgment of my physician. The risks, benefits and alternative options associated with the planned sedation/anesthesia have been explained to me. I have had the opportunity to ask questions and agree with the proposed plan.

I certify that I have read and understand the information regarding gastrointestinal endoscopy and that I have been fully informed of the risks and possible complications thereof: I hereby authorize and permit Dr. _____ and whomever he may designate as his assistants to perform upon me the following procedure:

Esophago-gastro-duodenoscopy/Colonoscopy with possible biopsies, possible polypectomy, possible coagulation/possible dilatation.

I recognize that during the course of the procedure, unforeseen conditions may require additional or difference medication, procedure or operation, including anesthesia and/or blood transfusion. Should this occur, I authorize the above named physician to perform procedures as are, in his/her professional judgment, necessary and desirable.

Signature: Patient or Legally Authorized Representative	Date	Time

Relationship to Patient: _____

Witness to Signature only	Date	Time
Signature of 2nd Witness (**For telephone/fax consent only**)	Date	Time

TRANSLATOR'S STATEMENT

I have verbally translated the above into _____ language for the benefit of the patient who better understands this language than English. To the best of my ability I believe that the patient understands the statements as witnessed by his/her signature on this consent form.

Translator's Signature	Date	Time

I certify that I have informed this patient of the proposed procedure/treatment, with risks associated with treatment, the alternative to treatment and the possible clinical outcome if the patient elects not to have the procedure/surgery/treatment.

Physician Signature	Date	Time