



Consent for Esophagogastroduodenoscopy

Patient _____ Procedure Date _____

* **Authorization and Nature of this Procedure:** I hereby request and authorize Dr. _____ and his associates/assistants to perform an **Esophagogastroduodenoscopy with possible biopsy and/or esophageal dilatation**. My physician has explained to me that this procedure is an examination of the lining of the esophagus, stomach and duodenum by use of a fiber optic scope, which is passed through the mouth into the esophagus, stomach and duodenum. During this procedure biopsies (tissue samples) may be removed. My physician has explained to me that stricture dilation is a procedure wherein a narrowed region of the esophagus, stomach or duodenum may be widened via the sequential passage of large diameter dilators. Occasionally when bleeding occurs, cautery or the injection of medication may be necessary to stop bleeding.

* **Risk and Complications:** Every medical procedure has some degree of risk and the possibility of complications. My physician has explained to me and I understand that complications from this procedure include but are not limited to: bleeding, infection, perforation of the esophagus, stomach or duodenum, aspiration of gastric contents into the lungs, or irregular heartbeat. Very rarely, death has been reported with this procedure. I understand that unusual complications, so rare that they are not routinely discussed before this test occasionally do occur. I do not wish to have further explanation given to me, although I have been advised that I am entitled to do so if I desire. I understand that I may be transferred to another facility in the event that complications occur. This decision will be made by my physician or designated health care provider.

* **Alternative Procedures or Treatment:** My doctor has explained to me that alternative procedures are available which also include risks and complications. I am satisfied with my physician's explanation of these options and wish to proceed with an Esophagogastroduodenoscopy. Such options may include x-rays, barium swallow, CAT scan, or no treatment.

* **Attendance of other Health Care Providers:** I understand that physicians, nurses and assistants may be present to perform and assist with my Esophagogastroduodenoscopy. I consent to the presence of these health care professionals and I do ___/ I do not ___ consent to students/residents/personnel in training to be present during my procedure.

* **Photographs:** I understand that photographs and/or videotaping may be taken during my procedure for documentation of findings. I do ___/I do not ___ consent to the use of these photographs to be used for teaching purposes. This includes the reproduction of the photographs for publication or to be used in part of a medical education program.

* **Tissue Disposal:** I consent to the appropriate disposal of any tissue removed during this procedure after the same tissue has been examined by a pathologist.

* **Anesthesia/Sedation:** I consent to the administration of intravenous (IV) medications that will have a sedative effect on me. Possible complications from this may include but are not limited to pain during the administration of medications, soreness/swelling in the arm, cardiac or respiratory arrest, rarely allergic reactions, which could cause death. I understand that I cannot drive after the procedure (until the following morning), should not sign any legal or important papers or perform tasks that require coordination. I should have a responsible adult with me for the remainder of the procedure day. I understand that advance directives will not be honored for the duration of this procedure.

* **No Guarantee or Assurance:** I acknowledge that no guarantee or assurance to the outcome of this procedure has been given to me. I do recognize that this is the best test for finding lesions in the esophagus, duodenum, or stomach; however, I understand that there is a low percentage of missed lesions (about 2-5%) associated with this procedure.

* **Opportunity for Further Information:** I understand that I am free to seek advice from other physicians if I choose. I know that I am also encouraged to ask questions regarding any aspect of this procedure that I am unclear or unsure of.

* **Opportunity to Read this Document:** I acknowledge by signing this consent that I have read this form in its entirety and fully understand it. I have had my questions answered to my satisfaction and agree and consent to this treatment.

DO NOT SIGN IF YOU HAVE FURTHER QUESTIONS

Signature of Patient or Authorized person _____ Date _____

Authorized person's relationship to the patient _____

Signature of Witness _____ Date _____

The above procedure(s) have been explained to the patient or authorized person to give consent for the patient.

_____, M.D.

Norfolk Office
160 Kingsley Lane, Suite 200
Norfolk, Virginia 23505
(757) 889-6800
Fax (757) 547-0145

Virginia Beach Office
5701 Cleveland Street, Suite 100
Virginia Beach, VA 23462
(757) 547-0798
Fax (757) 547-0145

Chesapeake Office
112 Gainsborough Square, Suite 200
Chesapeake, Virginia 23320
(757) 547-0798
Fax (757) 547-0145