

• INFORMED CONSENT FOR GASTROINTESTINAL ENDOSCOPY

Patient Label

Direct visualization of the digestive tract and abdominal cavity with lighted instruments is referred to as gastrointestinal endoscopy. Your physician has advised you of your needs to have this type of examination. The following information is presented 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 tissue (biopsy) may be removed for microscopic study, or the lining may be brushed and washed with a solution that can be sent for analysis of abnormal cells (cytology). Small growths can frequently be removed (polypectomy). Occasionally during the examination a narrowed portion (stricture) will be stretched to a more normal size (dilation).

The following are the principal risks of these procedures:

- Aspiration (breathing in) of stomach contents or saliva into the lungs during anesthesia.
- Injury to the lining of the digestive tract by the instrument which may result in perforation of the wall
 and leakage into body cavities; if this occurs, surgical operation to close the leak and drain the region is
 often necessary.
- Bleeding, if it occurs, usually is a complication of biopsy, polypectomy, or dilation; management of this
 complication may consist only of careful observation or may require blood transfusion or possibly a
 surgical operation for control.
- Infection
- Failure to diagnose.

Other risks include drug reactions and complications incidental to other diseases you may have. You should inform your physician of all your allergic tendencies and medical problems. All of these complications are possible, but occur with very low frequency. Your physician will discuss this frequency with you, if you wish, with particular reference to your own indications for gastrointestinal endoscopy.

The possible risks to having your procedure performed in an Ambulatory Surgery Center (ASC) setting are the same as listed above and may include the potential need for transfer to St. Mary Medical Center in the event of a complication. The benefits of having this procedure in an ASC are as follows:

- ASC's provide a safe, satisfying and cost-effective alternative to hospital based procedures
- Increased patient satisfaction due to ease of the ASC setting

A brief description of each endoscopic procedure follows:

- Upper Endoscopy (EGD or Esophagogastroduodenoscopy) is the examination of the esophagus from the throat to
 the entrance of the stomach, examination of the stomach, and examination of the small intestine just beyond the
 stomach (site of most ulcers).
- 2. Colonscopy is the examination of all or a portion of the colon requiring careful preparation with diet, enemas, and medication. During a colonoscopy a polypectomy may be performed. This is the use of a wire loop and electric current to remove small growths (Polyps). Patients with previous pelvic surgery and those with extensive diverticulosis may be more prone to complication(s).

During the procedure you will be receiving clinical anesthesia. The anesthesia medications will be administered through a catheter into your vein. Your vital signs will be monitored throughout the procedure. The risks of anesthesia include, but are not limited to: inflammation of the vein, bruising and/or discoloration at the injection site, trismus or spasm of the muscles of the face, lack of coordination, drowsiness, fainting, allergic reactions, vomiting, nausea, damage to teeth or oral tissues, necrosis of tissue at injection site; brain damage; paralysis; cardiac arrests and/or death. The possible or likely result of the intravenous anesthesia is to keep you in a sedate or sleep-like state.

Side 1 of 2



I realize that unexpected conditions may arise during my procedure, with which the physician may encounter, and I consent to additional procedures, which may be necessary to manage these conditions. I also authorize that you give me reasonable and proper medical care by today's standards.

For the purpose of advancing medical education, I consent to the admittance of qualified observers to the procedure room. Additionally, I consent to the taking and reproduction of any photographs and/or video in the course of this procedure for professional purposes.

I consent to the disposal, by The Endoscopy Center at St. Mary, of any tissue or body parts or foreign bodies which may be removed as a necessary part of my care.

I understand that I will be receiving sedation for my procedure and have been told that I will need to have someone drive me home, and may not drive or make any personal or business decisions until the day after my procedure.

I verify that I have received and read my Patients Rights and Responsibilities, Information on Advance Directives and the Disclosure of Physician Ownership. I understand that if I have any questions about the documents I may speak to my physician or nurse for clarification.

I certify that I understand the information regarding gastrointestinal endoscopy and anesthesia and that I have been fully informed of the risks, benefits, alternative treatments, complications and the prognosis if no treatment is received. I am also aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the proposed procedure. I have had sufficient opportunity to discuss my condition and treatment with the doctor, and all of my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to base an informed consent to the proposed procedure. Understanding all of the above, I intend to be legally bound by this informed consent which I am signing voluntarily after it has been completed and after I have had the opportunity to read **both** sides of this consent form.

I hereby authorize and permit	a	and whomever he may designate as his	
Assistant (s) to perform upon me an (circ specimen collection.	cle one): UPPER ENDOSCOPY / COL	ONOSCOPY, with or without	
SIGNATURE OF PATIENT	SIGNATURE OF WITNESS	DATE	
The Patient incompetent to give consent	because:		
Signature of person authorized to consent for the patient	Signature of Witness	Date	
Relationship to the Patient			
	PHYSICIAN'S CERTIFICATION		
I hereby certify I have discussed and exp operation/procedure in this consent with		uestions referring to the	
Physician's Signature		Date	

Revised 08/25/2011 Side 2 of 2