

UPPER GASTROINTESTINAL ENDOSCOPY

The procedure involves passing a flexible, lighted tube (an endoscope) through the mouth into the swallowing tube (esophagus), stomach, and first part of the small intestine (duodenum). This procedure allows your physician to examine the inside of these organs for various diseases. If a narrowing (esophageal stricture) is present, your physician will stretch (dilate) your esophagus. The procedure also permits the sampling of tissue (biopsy) if necessary. Abnormal growths such as polyps may be removed and submitted for analysis as well. Bleeding sites may be cauterized or varicose veins (varices) treated to prevent serious bleeding. Samples of secretions may also be collected. Medication may be given to minimize discomfort.

Patient's
Initials

- _____ The details of the procedure including the anticipated benefits and material risks have been explained to me in terms I understand.
- _____ Alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me.
- _____ I understand and accept that the most likely risks and complications of upper gastrointestinal endoscopy have been discussed with me and may include but are not limited to:
- *adverse reaction to sedation*
 - *bleeding*
 - *chronic disability*
 - *gagging/discomfort*
 - *pain*
 - *perforation of the esophagus*
 - *pneumonia*
- _____ I understand and accept that there are complications, including the remote risk of death or serious disability, that exist with any surgical procedure.
- _____ I have informed the doctor of all my known allergies.
- _____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.
- _____ I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.
- _____ I am aware and accept that no guarantees about the results of the procedure have been made.
- _____ I have been advised of the probable consequences of declining recommended or alternative therapies.
- _____ I have been informed of what to expect postoperatively, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.
- _____ I have arranged for transportation after my examination is complete.
- _____ I understand that any tissue/specimen removed during the surgery may be sent to pathology for evaluation.
- _____ The doctor has answered all of my questions regarding this procedure.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct _____, M.D., with associates or assistants of his or her choice, to perform an upper gastrointestinal endoscopy on _____ at _____.

(patient name) (name of facility)

Continued

I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

Patient or Legal Representative Signature/Date/Time

Relationship to Patient

Print Patient or Legal Representative Name

Witness Signature/Date/Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

Physician Signature/Date/Time

initial copy given to patient initial original placed in chart

SAMPLE