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INFORMED CONSENT FOR ESOPHAGOGASTRODUODENOSCOPY (EGD)

Procedure Date:_____**Time**:_____

1. I, _____ (patient or guardian) give consent for Dr. _____ or his/her associates to perform an EGD or upper gastrointestinal tract endoscopy with possible biopsy, polyp removal, dilation, esophageal band ligation and/or injection therapy of blood vessels or tissue, and control of bleeding if necessary.

2. I understand this procedure involves the passage of a digital optic instrument through the mouth to allow the physician to visualize the interior of the esophagus, stomach, and duodenum (first several inches of the small intestines). Sedation and pain relieving medications may be given to minimize discomfort and relax me for the procedure. These medications may cause localized irritation and/or a drug reaction. I understand that with the anesthesia/sedation for this procedure I will not be able to drive the remainder of the day and I should not have plans after the procedure. I understand that I MUST HAVE A DRIVER take me home

3. I understand the reasons for the procedure which have been adequately explained to me by my physician. I understand I may call the office where I regularly see my physician with any questions about the preparation or procedure. I have had ample opportunity to ask questions before signing this consent.

4. RISKS: Possible complications of this procedure include, but are not limited to: bleeding and tearing or perforation of the esophagus, stomach, or small intestines. These complications, should they occur, may require surgery, hospitalization, repeat EGD, and/or a transfusion. Perforation of the esophagus, stomach, or duodenum are known, but rare complications which can occur at a rate of less than 1 per 1,000 endoscopies. Bleeding, usually after a polyp removal, can occur at a rate of less than 1 per 1,000 endoscopies and continue up to two weeks after a polyp removal, can occur at a rate of less than 1 per 1,000 endoscopies and continue up to two weeks after a polyp is removed. Other extremely rare, but serious or possibly fatal risks include: difficulty breathing, heart attack, and stroke.

5. I understand that there are no guarantees regarding the results of this procedure. Alternative options as deemed medically relevant have been discussed and may include radiologic imaging tests. I understand that these tests have their own limitations and benefits.

6. I understand that it is my responsibility to know my insurance benefits coverage, including deductible and copayments. I understand that there are four potential fees associated with this procedure: FACILITY FEE, PHYSICIAN FEE, ANESTHESIA FEE, and PATHOLOGY FEE. I understand that I am responsible for any fees not covered by my insurance.

7. I have read and fully understand this consent form, and understand that I should not sign if all of my questions have not been answered to my satisfaction or if I do not understand any of the words or terms used in this form. IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED PROCEDURE OR TREATMENT, ASK YOUR PHYSICIAN NOW, BEFORE SIGNING THIS CONSENT FORM. SO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.

Patient/Legal Representative:

Signature:_____Date: _____Time: _____

Witness:

Signature:_____Date: _____Time: _____