UPPER ENDOSCOPY CONSENT FORM

CONSENT FOR PROCEDURE

SKYLINE ENDOSCOPY CENTER

Patient: _____

1. PROCEDURE AND ALTERNATIVES: I, (patient or authorized representative) authorize Dr._____ to perform procedure: **Esophagogastroduodenscopy (Upper Endoscopy, EGD) with possible biopsy, esophageal or gastric outlet dilation).**

I understand the reason for the procedure is: **Examination of the esophagus, stomach and duodenum with possible removal of tissue for diagnosis. There may also be possible dilation of a stricture of the esophagus or gastric outlet.**

Alternatives include: x-rays, do nothing, or _____

2. RISKS: This authorization is given with the understanding that any procedure involves some risks and hazards. The more common risks include: infection, bleeding, nerve injury, blood clots, heart attack, allergic reactions, aspiration pneumonia and missed lesions. These risks can be serious and possibly fatal. Some significant and substantial risks of this particular procedure include: **BLEEDING OR PERFORATION. IF EITHER OF THESE COMPLICATIONS OCCUR, TREATMENT MAY INCLUDE HOSPITALIZATION, SURGERY OR BLOOD TRANSFUSION.**

3. SEDATION AND ANESTHESIA: The administration of sedation and anesthesia also involves risks, most importantly a rare risk of reaction to medications causing death. I consent to the use of such sedatives or anesthetics as may be considered necessary by the person responsible for these services.

4. RESUSCITATION: I desire all resuscitative measures be employed during the procedure.

5. ADDITIONAL PROCEDURES: If my physician discovers a different, unsuspected condition at the time of the procedure, I authorize the physician to perform such treatment as deemed necessary to improve health.

6. I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure the condition.

7. I consent to the photographing of the procedure to be performed for medical purposes.

8. I consent to the admittance of medical or paramedical observers to the procedure room.

9. I hereby request and authorize this health care facility to preserve for scientific or teaching purposes or otherwise dispose of the removed tissue resulting from the procedures authorized above. I further authorize the pathologist, whose services may be required, to use discretion in the disposal.

NOTE: IF YOU HAVE ANY QUESTIONS ABOUT THE PROCEDURE, OR THE RISKS OR CONSEQUENCES ASSOCIATED WITH IT, TALK WITH YOUR PHYSICIAN. YOU MAY WITHDRAW THE CONSENT FOR THIS PROCEDURE AT ANY TIME PRIOR TO ITS PERFORMANCE. DO NOT SIGN THIS CONSENT UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.

_____ _____

Patient/Authorized Representative **Date and Time**

_____

Relationship of Authorized Representative

PHYSICIAN DECLARATION: I have discussed the procedure, risks, complications, consequences, and alternatives with the patient or patient's representative, and to the best of my knowledge, the patient or representative understands this information and consents to the proposed procedure.

_____

Physician's Signature