# Gastroenterology Associates

*Gastroenterology and Hepatology*
olygastro.com

## GASTROSCOPY (EGD/esophagogastroduodenoscopy) INFORMED CONSENT

*(Attach patient label with Name and DOB here)*

Washington State law guarantees that you have both the right and obligation to make decisions concerning your healthcare. Your physician can provide you with the necessary information and advice, but as a member of the healthcare team, you must enter into the decision-making process. This form has been designed to acknowledge your acceptance of treatment recommended by your physician.

1. I hereby authorize Dr. _____ (and/or such associates or assistants as may be selected by said physician) to treat the following medical condition(s)/problem(s) which has (have) been explained to me:
   _____
   _____
   _____
   _____
2. The procedure planned for treatment of my condition(s) has been explained to me by my physician. I understand it to be: **GASTROSCOPY (EGD):**
   Insertion of a flexible lighted tube into the mouth and advanced for exam of the esophagus, stomach and first part of the small intestine with possible biopsies or removal of abnormal growths and/or normal appearing tissue (depending on my condition) and possible use of devices or treatments such as injection, cautery or clips to stop or prevent bleeding or other specific treatment(s) for my condition(s). Biopsies will be sent for examination under microscope. Dilation may be done,
3. I recognize that during the course of the procedure, post-procedure care, medical treatment, moderate or deep sedation, unforeseen conditions may necessitate additional or different procedures than those set forth. I have been informed that various equipment and instrumentation may be used during my surgical procedures. **I therefore authorize my above-named physician, and his or her assistants or designees, to perform such surgical or other procedures as are in the professional judgement necessary and desirable.** The authority granted under this paragraph shall extend to the treatment of **all conditions** that require treatment and are not known to my physician at the time the procedure is commenced.
4. Like all invasive procedures, gastroscopy/EGD and possible dilation has some related risks. Adverse events may occur due to (1) medications that are given, (2) perforation, (3) bleeding, (4) disruption of the heart rhythm or breathing, (5) irritation of the veins where medications are given, (6) inhaling stomach contents into the lungs, (7) temporary chest pain from dilation,(8) unanticipated/ unknown reasons. A possible serious or life-threatening complication may occur in less than 1% of cases. Complications can lead to the need for hospitalization, blood transfusion, or surgery. My doctor believes that in my case, the risks of the procedure are small compared to the benefits of the procedure. **I acknowledge that no warranty or guarantee has been made to me as to result or cure.**
5. I certify that my doctor has informed me of the nature and character of the proposed treatment, of the anticipated results of the proposed treatment, of possible alternative forms of treatment, and the anticipated benefits involved in the proposed treatment and in the alternative forms of treatment, including non-treatment.

**Any sections below that do not apply to the proposed treatment may be crossed out. All sections crossed out must be initialed by both physician and patient.**

1. I consent to moderate or deep sedation and topical anesthesia. The risk(s) and alternatives (i.e., no sedation) have been explained to me by my doctor.
2. Any tissues or parts surgically removed may be disposed of by the pathologist or procedure physician in accordance with accustomed practice.
3. I consent to the admittance of qualified observers in the procedure room, as determined by my doctor.
4. I consent to records release in the event of urgent or emergent transfer to the hospital.

I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents.

**PATIENT COPY - DO NOT SIGN** _____ Date _____ Time _____ AM/PM
Patient/Other Legally Responsible Person Sign

**PATIENT COPY - DO NOT SIGN** _____ Date _____ Time _____ AM/PM
Witness Sign

**PATIENT COPY - DO NOT SIGN** _____ Date _____ Time _____ AM/PM
Physician Sign