SUMMIT ENDOSCOPY CENTER, LLC

INFORMED CONSENT: ESOPHAGOGASTRODUODENOSCOPY (EGD)

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND ITS CONTENTS

NAME OF PROCEDURE: Esophagogastroduodenoscopy (EGD)

The following has been explained to me in general terms and I understand that:

1) The diagnosis requiring this procedure is (diagnosis described in layman's terms): _____

_____

2) The nature of the procedure is(describe procedure in layman's terms): insert a flexible lighted tube through the mouth, down into the swallowing tube, stomach and upper intestine. Take small samples of tissue and/or perform therapeutic measures and possible dilation of narrowed area in the esophagus or stomach outlet.

3) MATERIAL RISKS OF THIS PROCEDURE: As a result of this procedure, being performed there may be material risks of: DAMAGE TO TEETH OR DENTAL WORK, INFECTION, ALLERGIC REACTION, DISFIGURING SCAR, SEVERE LOSS OF BLOOD, LOSS OR LOSS OF FUNCTION OF ANY LIMB OR ORGAN, PARALYSIS, PARAPLEGIA OR QUADRIPLEGIA, BRAIN DAMAGE, CARDIAC ARREST OR DEATH, VEIN THROMBUS OR IV INFILTRATION LEADING TO TISSUE DAMAGE.

4) In addition to these material risks, there may be other possible risks, involved in this procedure including but not limited to: **perforation and/or bleeding, possibly requiring surgery and infection.**

5) The likelihood of success of the above procedure is:

(X) Good ( ) Fair ( ) Poor

6) Practical alternatives to this procedure include: _____

( ) None (X) Observation (X) Other: x-ray

7) If I choose not to have the above procedure, my prognosis (future medical condition) is:

(X) Uncertain ( ) Poor ( ) Other: _____

I understand that the physician, medical personnel and other assistants will rely on statements about the patient, the patient's medical history, and other information in determining whether to perform the procedure or the course of treatment or the patient's condition and in recommending the procedure that has been explained.

I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the results of this procedure.

I understand that during the course of the procedure described above it may be necessary or appropriate to perform additional procedures, which are unforeseen, or not known to be needed at the time this consent is given. I consent to and authorize the persons described herein to make the decisions concerning such procedures. I also consent to and authorize the performance of such additional procedures, as they deem necessary or appropriate.

I also consent to diagnostic studies, tests, anesthesia, x-ray examinations and any other treatment or courses of treatment relating to the diagnosis or procedures described herein.

I also consent that any tissues, specimens, organs or limbs removed from the patient's body in the course of any procedure may be tested or retained for scientific or teaching purposes and then disposed of within the discretion of the physician, faculty or other health care provider.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME, THAT I FULLY UNDERSTAND ITS CONTENTS, WHICH I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ANY QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY. ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ALL STATEMENTS I DO NOT APPROVE OF WERE STRICKEN BEFORE I SIGNED THIS FORM. I ALSO HAVE RECEIVED ADDITIONAL INFORMATION INCLUDING BUT NOT LIMITED TO THE MATERIALS LISTED BELOW, RELATED TO THE PROCEDURES DESCRIBED HEREIN.

I hereby voluntarily request and consent to the performance of the procedures described or referred to herein by Dr. _____ and any other physicians or other medical personnel whom may be involved in the course of my treatment.

_____ **OUTSIDE OBSERVERS:** If for education or accreditation purposes, a person other than the Physician and assistant may be present in the room during the procedure you must indicate your consent by initialing on the line at the beginning of this section.

_____ X_____

Witness
(to signature only)

Person giving consent

Time consent signed:

_____

Relationship to patient if not the patient_____

Patient unable to sign because of: _____

_____

Additional materials used, if any, during the informed consent process for this procedure included:

_____

I have discussed IV sedation with this: Patient (X) Spouse ( ) Family ( ) Parent ( )
(X) Appropriate candidate for IV sedation
(X) Options, risks, and benefits of sedation have been discussed with patient.
Patient (Patient's Guardian) agrees with plan (X) YES ( ) NO

Physician obtaining consent: _____