PRMC DISCLOSURE AND CONSENT FOR
UPPER GASTROINTESTINAL ENDOSCOPY PROCEDURE
WITH POSSIBLE ESOPHAGEAL DILATATION

TO THE PATIENT: *You have the right, as a patient to be informed about your condition and the recommended endoscopy procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent for the procedure.*

I voluntarily request Dr._____as my physician and such assistants as he may designate to treat my condition which has been explained to me as_____

I understand that the following surgical, medical and diagnostic procedures are planned for me and I voluntarily consent and authorize these procedures; Upper Gastrointestinal Endoscopy_____

I understand that my physician may discover other or different conditions which require additional or different procedures than those planned. I authorize my physician, and such associates, technical assistants, and other health care providers to perform such other procedures which are advisable in their professional judgment.

I understand this procedure involves passage of a flexible fiberoptic instrument through my mouth and back of my throat to allow the doctor to visualize the interior of my esophagus, stomach and upper small intestine.

I understand that a sedative medication may be administered to allow me to tolerate the procedure by relieving anxiety, discomfort or pain. The risks of sedation medication include **allergic reaction, loss of protective reflexes and cardiac or respiratory depression that could result in brain damage, cardiac arrest, or death.**

I understand that possible complications from this procedure include, but are not limited to, **tearing or perforation of the wall of the esophagus, stomach, or upper small bowel, bleeding, dental damage, infection, unpredictable reaction to medications and other rare complications**. These complications are extremely rare, but may require surgery.

If necessary, I also agree to the removal of a polyp or polyps if present by electrical cauterization and/or removal of small pieces of tissue by biopsy for examination under the microscope, though both are accompanied by a slightly greater risk of complication, including **bleeding.** Rarely transfusions and/or surgery may be required.

I **(DO) pt_____witness_____ (DO NOT) pt____witness_____**consent to the use of blood and blood products as deemed necessary. I understand the risks and hazards associated with the use of blood and blood products are: fever, transfusion reaction which may include kidney failure or anemia, heart failure, hepatitis, AIDS (Acquired Immune Deficiency Syndrome) and other infections.

If necessary, I agree to electrical cauterization of a bleeding site if deemed necessary by my physician. This is accompanied by a slightly greater risk of complications, including **perforation and increased bleeding.**

I understand that if dilatation is required it involves the passage of a dilator through my mouth and back of my throat or passage of a balloon dilator through the scope, over a guide wire if necessary, to enlarge a narrowing in my esophagus. This procedure may cause some discomfort including chest pain and sore throat and possible infection. Complications of dilatation include, but are not limited to, **tearing and sometimes perforation of the wall of the esophagus and bleeding. Rarely transfusion or surgery may be required.**

I understand and agree that photographs may be taken of the inside of my stomach or intestine during this procedure.

I understand that no warranty or guarantee has been made to me as to the result of the procedure.
I have been given an opportunity to ask questions about my condition, possible alternative procedures, the procedures to be used, and the risks and hazards involved, and believe that I have sufficient information to give this informed consent.
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.

DATE_____TIME_____ _____
PATIENT OR OTHER LEGALLY RESPONSIBLE PERSON SIGN (RELATIONSHIP)

_____ _____ _____
WITNESS (Print and signature) WORK ADDRESS CITY, STATE, ZIP CODE

PHYSICIAN CERTIFICATION

I hereby certify that I have explained the nature, purpose, benefits, the usual and most frequent risks and hazards of, and alternatives to, the proposed procedure. I have offered to answer any questions and have fully answered such questions. I believe that the patient/relative/guardian understands what I have explained and has consented to undergo the proposed procedure.

Physician signature_____Date_____Time_____

This form is designed to comply with the requirements promulgated by the Texas Medical Disclosure Panel