

**INFORMED CONSENT FOR ENDOSCOPIC
GASTROINTESTINAL PROCEDURES**

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AN INTERPRETER SERVICE IS REQUIRED: Yes No**Endoscopic Gastrointestinal Procedures:**

Endoscopic gastrointestinal procedures are performed by passing fiber-optic endoscopes through the mouth or anus to examine the GI tract. Through the endoscope the esophagus, stomach, first portion of the small intestine, and the colon can be examined. Various treatments, tissue sampling (biopsies), and removal of polyps can be performed. Some endoscopic procedures are performed under sedation.

- Procedural Sedation:** Medications are given to alleviate anxiety and/or pain associated with some procedures. If procedural sedation is used, medication will be given through an intravenous line (IV) prior to and during the procedure. The patient's vital signs will be monitored carefully throughout the procedure. Colonoscopy and upper endoscopy are usually performed under procedural sedation. Flexible sigmoidoscopy is usually performed without sedatives.
- Colonoscopy:** The colonoscope is introduced via the rectum to examine the entire colon. If polyps are found, most can be removed through the colonoscope. Biopsies may be taken for samplings from large polyps, masses, and other abnormal findings, or surveillance of chronic conditions (i.e., inflammatory bowel disease).
- Esophagogastroduodenoscopy (EGD):** The endoscope is introduced via the mouth to examine the esophagus, stomach, and the first portion of the small intestine (duodenum). Treatments can be performed to stop bleeding from ulcers, esophageal varices, and small blood vessels. Biopsies may be taken for testing of stomach bacteria, samplings from masses and other abnormal findings, or surveillance of chronic conditions (i.e., Barrett's esophagus).
- Sigmoidoscopy:** The sigmoidoscope is introduced via the rectum to examine the lower portion of the colon. Small polyps can be removed through the sigmoidoscope. Some patients with polyps may proceed to colonoscopy. Masses and other abnormalities can be biopsied.

Benefits:

You may receive the following benefits. The doctors cannot guarantee you will receive any of these benefits. Only you can decide if the benefits are worth the risks.

1. Ability to examine the GI tract
2. Ability to perform tissue sampling
3. Ability to perform treatment

Risks:

Before undergoing one of these procedures, understanding the associated risks is essential. Even with our best efforts, no procedure is completely risk-free. The following risks are well recognized, but there may also be other unforeseen risks. Colonoscopy is an excellent test for colon cancer and polyps, but like all tests it is not perfect and it does not detect every large polyp or cancer. A normal examination does not guarantee that there will be no future cancers. The following side effects are possible:

1. Bleeding after polyp removal, biopsy, or passage of the endoscope
2. Perforation to the bowel
3. Allergic reactions to the sedatives
4. Inflammation of intestine lining
5. Small polyps and other abnormalities may be missed during procedure
6. Cardiorespiratory suppression may occur with the use of sedative
7. Surgery may be required for major complications



Fremont/Hayward Medical Center
The Permanente Medical Group, Inc.

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MR #: _____

Name: _____

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Alternatives:

The alternatives to these procedures include radiologic tests such as barium enema, upper GI series, computerized tomography (CT scan), and magnetic resonance imaging (MRI). These tests have fewer risks but do not allow for the performance of treatments, tissue removal, and sampling.

The following physicians or other practitioners are expected to perform the tasks indicated above.

Name of Practitioner: _____

Name of Practitioner: _____

If any of the practitioners named above are unable to perform or complete the task, a substitute may do so, and this information will be recorded in your medical record.

If you have further questions about the procedure, the doctor will answer them before you sign this consent form.

My signature below indicates: 1) I have read and understood the above information, 2) I have had explained to me the risks, benefits, alternatives, and risks of the alternatives, 3) I have had the opportunity to ask questions and they have all been answered to my satisfaction, and 4) I wish to proceed. 5) If indicated, I agree to disclose the results and other information about my procedure to the designated person.

I authorize the following person to receive results and other information about my procedure.

Name: _____ Relationship: _____

SIGNATURE OF PATIENT		SIGNATURE OF WITNESS		
SIGNATURE OF RELATIVE OR PATIENT'S LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT	DATE	TIME	<input type="checkbox"/> AM <input type="checkbox"/> PM

The patient stated back, in his/her own words, the procedure or treatment that is being consented to, and associated benefits and risks.

SIGNATURE OF PHYSICIAN	PRINT NAME
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Interpreter's Statement: I have accurately and completely read the foregoing document to (print name of patient or patient's legal representative) _____, in the patient's or legal representative's primary language _____ (identify language). He/she has understood all of the terms and conditions and acknowledged his/her agreement by signing the document in my presence.

Interpreter Identification Number: _____ (If Universal Language Telephone is used)

INTERPRETER'S SIGNATURE	PRINT NAME
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