

BRYN MAWR MEDICAL SPECIALISTS ENDOSCOPY CENTER
INFORMED CONSENT FOR GASTROINTESTINAL ENDOSCOPY

Direct visualization of the digestive tract and abdominal cavity with lighted instruments is referred to as gastrointestinal endoscopy. Your physician has advised you of your need to have this type of examination. The following information is presented to help you understand the reasons for, and possible risks of, these procedures.

At the time of your examination, the inside lining of the digestive tract will be inspected thoroughly and possibly photographed. If an abnormality is seen or suspected, a small portion of tissue (biopsy) may be removed for microscopic study, or the lining may be brushed and washed with a solution that can be sent for analysis of abnormal cells (cytology). Small growths can frequently be removed (polypectomy). Occasionally during the examination a narrowed portion (stricture) will be stretched to a more normal size (dilation).

The following are the principal risks of these procedures:

- Injury to the lining of the digestive tract by the instrument which may result in perforation of the wall and leakage into body cavities; if this occurs, surgical operation to close the leak and drain the region is often necessary.
- Bleeding, if it occurs, usually is a complication of biopsy, polypectomy, or dilatation; management of this complication may consist only of careful observation or may require blood transfusion or possibly a surgical operation for control.
- Injury to the spleen can rarely occur.
- Despite a thorough examination, there is a small incidence of missed polyps and tumors.

Other risks include, but are not limited to, drug reactions and complications incidental to other diseases you may have. You should inform your physician of all your allergic tendencies and medical problems. All of these complications are possible, but occur with very low frequency. Your physician will discuss this frequency with you, if you wish, with particular reference to your own indications for gastrointestinal endoscopy. In the rare event of a medical need during and /or after the procedure, you may require admission to the hospital.

A brief description of each endoscopic procedure follows:

1. **EGD (Esophagogastroduodenoscopy):** Examination of the esophagus, stomach (site of most ulcers) and duodenum. Biopsy, cytology, specimen collection and dilatation of strictures may be necessary.
2. **Sigmoidoscopy:** examination of the anus, rectum, and lower colon (large intestine), usually to a depth of 25-60 centimeters (10-25 inches). If polyps (small growths that protrude into the colon) are found, they may be removed using a biopsy forcep, wire loop with or without electric current (polypectomy).
3. **Colonoscopy:** examination of all or a portion of the colon requiring careful preparation with diet, enemas, and medication. Patients with previous pelvic surgery and those with extensive diverticulosis may be more prone to complication(s). If polyps (small growths that protrude into the colon) are found, they may be removed using a biopsy forcep, wire loop with or without electric current (polypectomy).

I certify that I understand the information regarding gastrointestinal endoscopy and that I have been fully informed of the risks, benefits, alternative treatments, complications and the prognosis if no treatment is received. I have been informed of the comparative risks, benefits and alternatives associated with performing the procedure in the ambulatory surgical facility instead of in a hospital. I am also aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the proposed procedure.

**BRYN MAWR MEDICAL SPECIALISTS ENDOSCOPY CENTER
INFORMED CONSENT FOR GASTROINTESTINAL ENDOSCOPY**

I have had sufficient opportunity to discuss my condition and treatment with the doctor, and all of my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to base an informed consent to the proposed procedure.

I hereby authorize and permit _____, and whomever he/she may designate as his/her assistant(s) to perform upon me the following procedure(s):

I realize that unexpected conditions may arise during my procedure, with which the physician may encounter, and I consent to additional procedures, which may be necessary to manage these conditions. I also authorize that you give me reasonable and proper medical care by today's standards. Although the Center respects the patient's right to participate in decisions regarding their healthcare, i.e.: advanced directives, it is their policy that all patients undergoing endoscopic procedures will be considered eligible for life sustaining emergency treatment. In the event an emergency transfer to the hospital is necessary, patients presenting with an Advance Directive will further be informed that their Advanced Directive will follow them to the hospital, in which case the Advanced Directive will go into effect upon admission to a hospital.

For the purpose of advancing medical education, I consent to the admittance of qualified observers to the procedure room. Additionally, I consent to the taking and reproduction of any endoscopic photographs in the course of this procedure for professional purposes.

I consent to the disposal, by Bryn Mawr Medical Specialists Endoscopy Center, of any tissue or foreign bodies, which may be removed as a necessary part of my care. All specimens will be sent to the lab for analysis.

Understanding all of the above, I intend to be legally bound by this informed consent, which I am signing voluntarily after it has been completed and after I have had the opportunity to read, and fully understand it. I hereby authorize the performance of the above noted procedure.

Signature of Patient

Signature of Witness

Date

Time

PHYSICIAN'S CERTIFICATION

I hereby certify I have discussed and explained the procedure and answered any questions referring to the operation/procedure in this consent with the individual granting consent.

Physician's Signature

Date

If the patient is incompetent to give consent complete the following:
Patient is incompetent to give consent because:

Signature of person authorized
to consent for the patient

Signature of Witness

Date

Relationship to the Patient: _____