Ambulatory Endoscopy Center of Maryland
Corridor Anesthesia

Informed Consent for Procedures

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 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 completely removed (polypectomy). Occasionally during the examination a narrowed portion (stricture) will be stretched to a more normal size (dilation).

_____ Intravenous Sedation: Conscious Sedation/Monitored Anesthesia Care (MAC). Medications are administered through an intravenous (IV) site to make the patient sleepy and comfortable for the test. MAC sedation will be administered only by a Certified Registered Nurse Anesthetist (CRNA).

_____ Esophagogastroduodenoscopy with possible biopsy: Examination of the esophagus from the throat to the entrance of the small intestine just beyond the stomach (site of most ulcers), frequently done at the same time as esophagostomy. Biopsy, cytology, specimen collection, and dilation of strictures (below) may be necessary.

_____ Esophageal Dilation: There are two methods of dilation:

1. Balloon Dilator: a flexible catheter with various size balloons is passed through the endoscope. The balloons are inflated in the esophagus and/or pylorus.

2. Savory Dilator: a flexible polyvinyl tube that slides over a guide wire (placement of the guidewire into the esophagus is done during upper endoscopy).

_____ Colonoscopy with possible biopsy and/or polypectomy: Examination of all or a portion of the colon requiring careful preparation with diet, enemas and/or medication. A wire loop or hot biopsy forcep is used to remove all small growths that protrude into the colon. Patients with previous pelvic surgery and those with extensive diverticulosis may be prone to complications.

_____ Other:

_____

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

1. The diagnosis requiring this procedure is known to me.
2. The nature of the procedure is checked off and initialed by me as indicated on above.
3. As a result of this procedure being performed, there may be risks or potential complications including: abnormal heart rhythm, trouble breathing, aspiration, allergic or adverse reaction to the sedative medications, bleeding, the possibility of missing a lesion, perforation of the gastrointestinal tract, infection, thrombosed vein, IV infiltration, phlebitis, nerve injury from IV catheter, injury to internal organs or death.
4. Teeth and dental prosthetics (such as dental implants, veneers, caps, crowns and bridges) may become loose, broken, or dislodged, regardless of the care provided. By signing this consent, you are acknowledging that neither your anesthesia providers, physician, the facility nor the company employing or engaging the anesthesia providers will be responsible for any dental damage or repair costs.

I understand that there are risks with any procedure and it is impossible for the physician to inform me of every possible complication.

I understand that my physician, medical personnel and other assistants have relied on statements about my medical history and other information in determining the need for this procedure and course of treatment.
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 therein 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 consent to diagnostic studies, tests, anesthesia, x-ray examinations and other treatment or courses of treatment relating to the diagnosis or procedures described therein.

I also consent that any tissues or specimens 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 or pathology lab.

I further consent to the taking and reproduction of any photographs in the course of this procedure for professional purposes.

In the event my physician, anesthesia provider, staff or other patient is exposed to my blood, bodily fluids or contaminated materials, I agree to allow testing that will determine the presence of HIV and Hepatitis. An accredited laboratory, at no cost to me, will perform all required laboratory tests.

BY SIGNING THIS FORM I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME, THAT 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 hereby voluntarily request and consent to the performance of the procedure described or referred to herein by Dr. _____ and any other physicians or other medical personnel who may be involved in the course of my treatment.

_____ _____
Signature of patient or Authorized Representative Date and Time

FOR SIGNATURE AT FACILITY

_____ _____
Witness' Signature Date and Time

I certify that I have explained to the patient/responsible adult the indications, risks, benefits and alternatives of the procedure and have allowed the patient/responsible adult to ask questions.

_____ _____
Physician Signature Date and Time

I certify that I have explained to the patient/responsible adult the options and medically acceptable alternatives, as well as the material or substantial risks and benefits of the planned sedation and have allowed the patient/responsible adult to ask questions.

_____ _____
Signature of Anesthesia Provider Date and Time