

Consent for Esophagogastroduodenoscopy (EGD)

I hereby authorize Dr. _____ and his/her assistants to perform my EGD.

- A. I understand that an EGD procedure requires my gastroenterologist to insert a lighted scope into my mouth, then into the esophagus, stomach and duodenum which is the first segment of the small intestine.
- B. I understand that, during the procedure my doctor may find it necessary to perform an intervention(s) including but not limited to the following:
- Tissue biopsy and/or polyp (or other growth) removal
 - Esophageal or stomach dilation
 - Tissue cauterization to stop bleeding
 - Injection of medication into my esophagus or stomach to relax a sphincter or to stop bleeding
 - Injection of ink or stain to tattoo an area that may be abnormal
- C. I understand that, if I have a biopsy, my tissue may be sent to a pathologist for analysis and I consent to the retention or disposal of such tissue.
- D. I understand that complications may occur during the procedure even though the procedure is done absolutely properly by an experienced gastroenterologist. Furthermore, I understand that although it is impossible for my physician to inform me of every possible complication, the serious complications include, but are not limited to the following:
- Perforation of the esophagus, possibly resulting in hospitalization and surgery
 - Aspiration pneumonia resulting from the movement of stomach contents backwards into the mouth and then down into the lung
 - Infection, phlebitis, and/or nerve injury related to the IV catheter or IV medications administered
 - Bleeding requiring transfusion or hospitalization
 - Heart or lung problems related to anesthesia
 - Dental injury from a scope instrument
 - Death related to a complication of the procedure
- E. I understand that my physician may request the presence and assistance of another doctor, should such assistance be considered necessary for my care. Permission is granted for a manufacturer's representative, for technical assistance, or a student, for continuing education, to be in attendance during my procedure if the situation arises.
- F. I understand that, should a member of the staff become exposed to my body fluid, I will consent to having my blood tested for HIV and Hepatitis.

- G. I understand the Mid-Atlantic Endoscopy Center’s policy regarding Advance Directives i.e. how my care will be managed should I become unable to relay my requests.
- H. I understand the surgical and/or diagnostic procedures performed on me at the Center will be done on an outpatient basis and the Center does not provide 24 hour patient care. If my attending practitioner or any other qualified physician in his/her absence, shall find it necessary or advisable to transfer me from the Center to another healthcare facility, I consent and authorize the employees of the Center to arrange for and effect the transfer.
- I. I understand and agree that all practitioners who furnish services to me at the Center, including my physician, anesthesia provider, pathologist, and the like are independent contractors with me and not employees of the Center.
- J. Anesthesia services are being provided by First State Anesthesia and I will sign a separate consent for those services.

Certification of Patient and Witness:

I understand and accept all aspects of the written material in this consent form, have been given opportunity to ask questions, and wish to proceed with an EGD examination.

Patient/Legal Guardian signature: _____ Date/time: _____

Witness signature: _____ Date/time: _____

Gastroenterologist’s Certification:

I certify that I have explained the EGD procedure to my patient, along with alternatives to the procedure, including doing no test. Physician

Signature: _____ Date/time: _____