Central Illinois Endoscopy Center

Upper Endoscopy (EGD) Informed Consent Form

I _____ DOB: _____ do hereby authorize _____, MD, and any assistant(s) he/she may designate to perform upon me the procedure of: EGD WITH POSSIBLE BIOPSY AND/OR POLYPECTOMY AND/OR DILATION AND/OR PEG PLACEMENT (EGD/PEG) with the accompanying moderate sedation/analgesia as necessary.

1. I understand that this is a procedure performed to examine the inside of my esophagus, stomach and duodenum. The examination uses a long flexible, fiberoptic lighted tube that allows for viewing inside of these organs. The physician inserts the fiberoptic tube into your mouth and moves it into your gastrointestinal tract. This procedure requires intravenous sedative and local anesthetic to help you relax.
2. I understand that this procedure is generally safe, but certain risks accompany any endoscopic procedure. The risks of an Upper Endoscopy include, but are not limited to the following:
    - Perforation (a hole is created in the lining of the esophagus, stomach, or duodenum) this may require surgery to repair. The risk is increased when there is a biopsy taken, a polyp removed, or the esophagus dilated.
    - Bleeding. The risk is increased when there is a biopsy taken or a polyp removed. This is usually minor and can usually be stopped through the endoscope. Rarely, surgery is needed to stop the bleeding.
    - Reactions to IV sedative drugs/topical anesthetic spray including but not limited to rash, low blood pressure, breathing difficulty, irritation of the skin, and impaired oxygen delivery.
    - A small possibility that you cannot be completely sedated and therefore may experience some pain and discomfort during the procedure.
    - Rare, unusual reactions, including possible death, following any endoscopic procedure.
    - Infection.
    - Broken teeth.
3. I understand that the practice of medicine is not an exact science, and that no guarantee can be made regarding the outcome of my planned procedure.
4. I understand that an Upper GI barium x-ray is an alternative to this procedure.
5. I understand/that if any immediate life-threatening events happen during the procedure, they will be treated accordingly.
6. I understand that an Upper Endoscopy is not completely accurate and occasionally abnormalities, including cancer may be missed.
7. A resident (doctor still in training) may participate in my procedure, as well as the extent of the resident's participation and I have agreed to the resident's participation. I understand that I may refuse to be involved in the formal training of medical and other students without this affecting my care and treatment in a negative way.
8. I consent to the entering of authorized personnel and observers including students to the procedure room.
9. I consent to the photographing, videotaping, audio or other digital recordings, or televising of the operations or procedures to be performed including necessary portions of my body for medical, scientific or educational purposes. I understand that my identity will not be revealed by the pictures or by writings that accompany them and I have the right to request the stopping of any recording or filming. I consent to the pictures or by writings that accompany them and I have the right to request the stopping of any recording or filming.
10. **I CERTIFY THAT I HAVE READ OR HAD READ TO ME THE CONTENTS OF THIS FORM. I UNDERSTAND THE RISKS, SIDE EFFECTS AND ALTERNATIVES INVOLVED IN THIS PROCEDURE. I HAVE HAD THE OPPORTUNITY TO ASK ANY QUESTIONS WHICH I HAD AND ALL OF MY QUESTIONS WERE ANSWERED.**

_____ Date: _____ Time: _____

(Signed by patient or patient legally authorized to consent for patient)

Date _____Time _____ Signature of witness_____Print Name_____

PHYSICIAN DECLARATION: I have explained the contents of this document to the patient and have answered all the Patients/authorized Representative questions. To the best of my knowledge, I feel the patient has been adequately Informed and has consented.

_____ _____

Physician's Signature Date/Time

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PHYSICIAN OWNERSHIP DISCLOSURE FORM

In accordance with Federal ASC Regulations (42 C.F.R. 416.50(a)(ii)), the following ownership disclosure is made in advance of the date of the procedure:

Central Illinois Endoscopy Center is owned in part by the physicians of Illinois Gastroenterology Institute. The physician who will be performing your procedure is an owner of that practice.

You have the option to be treated at another health care facility such as OSF Saint Francis Medical Center, Unity Point - Methodist, or Unity Point - Proctor.