



# The Endoscopy Center

817 Lawn Avenue, Sellersville, PA 18960 215.453.3050

## Consent For Upper Endoscopy

**Patient** \_\_\_\_\_ **Date** \_\_\_\_\_

**Introduction:** Your Doctor, \_\_\_\_\_ has scheduled you for an examination of the esophagus, stomach and duodenum using a flexible tube or endoscope. We are asking that you read and sign this form to insure your understanding of the procedure and the risks involved, and to document your consent to undergo the procedure and accept the risks.

**Procedure:** You will likely be given sedation through an intravenous injection prior to the examination. Following this, the flexible instrument will be placed through your mouth and inside the esophagus, stomach, and duodenum so your doctor may examine these areas. Biopsies may be taken during this procedure. The following additional procedures may be performed \_\_\_\_\_.

**Risks:** In general, Endoscopy is safe, but there are some risks associated with the procedure and the sedation. Complications or a poor outcome do not differ whether the procedure is performed in an ambulatory surgical facility or a hospital environment. Serious complications include a risk of bleeding or perforation of the esophagus, stomach or duodenum occurring in less than 1 of 10,000 cases. In addition, there is a small risk of an allergic reaction to the sedative you receive, and a small risk that the sedative could compromise the function of the heart or your breathing. Monitoring of your heart, blood pressure, and breathing during the procedure help minimize these risks.

If additional procedures are performed during the Endoscopy, the risks may be greater and are listed here:

\_\_\_\_\_.

In general, the overall risk of a complication is quite small, but if a serious problem arises it may necessitate blood transfusions or emergency surgery, and in very rare instances may result in death. In the event of a complication you would be transported to a hospital for treatment.

**Alternatives:** There may be other alternatives that your physician could use to help diagnose your problem, including barium x-ray tests or surgery. If you are reluctant to have the Endoscopy, discuss with your doctor.

**Agreement:** I understand the information on this form and have had the opportunity to discuss any other questions I may have with my doctor. I consent to the taking of photographs in conjunction with the procedure. I agree to have the procedure performed and accept the risk involved. I consent to the taking of photographs in conjunction with the procedure, and their future use as per my physician.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Patient or Relative

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Physician

Patient was identified prior to the procedure \_\_\_\_\_

Physician Signature