ENDOSCOPY CENTER OF BUCKS COUNTY
INFORMED CONSENT- ESOPHAGOSCOPY (EGD)

AUTHORIZATION FOR TREATMENT: I, _____, authorize Dr. _____
and/or his associates to perform the following diagnostic or therapeutic ESOPHAGOGASTRODUODENOSCOPY (also known as upper endoscopy or EGD)

Procedure: This examination consists of the placement of a flexible instrument with a light and camera at the tip through the mouth into the esophagus (food tube), stomach, and first part of the small intestine. The lining of these structures are then examined and samples (biopsies) may be taken to examine under the microscope. Additional procedures, including but not limited to, removal of small growths or polyps (polypectomy), stretching of the esophagus or stomach outlet (dilation), and cautery/injection/banding of abnormal blood vessels may also be carried out if necessary. Before the procedure, an intravenous catheter will be placed through which I will be given medications (anesthetics) to make me comfortable during the procedure. I understand that during the course of the procedure, unforeseen conditions may become apparent which would require an extension of the original procedure or even a different procedure. I authorize the above named physician(s) to perform such procedures or transfer to a hospital as deemed necessary and advisable in the exercise of his/her (their) professional judgment.

I understand and acknowledge that by signing this form I am representing in writing that I have been fully informed to my satisfaction in general terms of the following:

a. A diagnosis of the condition requiring the procedure(s).
b. The nature and purpose of the procedure(s).
c. The potential benefits, risks and side effects associated with the procedure(s).
d. The reasonable alternatives to the procedure(s) including relevant risks, benefits and side effects.
e. The comparative risks, benefits and alternatives associated with performing a procedure in an ambulatory surgical facility instead of a hospital.

and that such information was provided through the use of pamphlets, booklets or other means of communication and through direct conversation with the responsible physician or other health care providers under the supervision and control of the responsible physician. Complications are unusual but can occur and include: 1) unexpected allergic reaction to the medication used, 2) a tear in the lining of the esophagus, stomach or small intestine, 3) bleeding which may require transfusions, 4) failure to diagnose as this is not a perfect test, 5) infection, 6) swallowing of stomach contents into the lungs (aspiration) or problems with heart or lung function associated with the procedure or sedation. These risks are somewhat increased if the additional procedures noted above are performed. Occasionally, the procedure may not be completed or lesions may be missed. Treatment of complications may require hospitalization, antibiotics, additional procedures, blood transfusions, surgery or other measures deemed advisable for my health and well-being.

I consent to the drawing and testing of my blood in the event that an individual is accidentally exposed to my body fluids. The results of these tests will remain strictly confidential, except as specified by law.

Alternatives: there may be other tests or procedures that my physician could use as an alternative and which I have had the opportunity to discuss.

Patient Self-Determination Act of 1990/Advanced Directives: I acknowledge that the Endoscopy Center of Bucks County has available to me written information on my rights and responsibilities to make health care treatment decisions in compliance with the Patient Self-Determination Act of 1990. I also understand that I am consenting to have an elective procedure performed upon me at this facility, therefore Endoscopy Center of Bucks County will not honor Advance Directives (Living Will).

Personal Valuables: I understand that the Endoscopy Center of Bucks County provides facilities for the safekeeping of any valuable and any valuables kept by the patient are kept at the patient's risk. I hereby accept full responsibility for any personal effects taken to the procedure room, including such things as dentures, eyeglasses, contact lenses and hearing aids.

Consent and Acknowledgment: by signing this form, I acknowledge that I have read and understand this consent form and have received sufficient information regarding the above mentioned procedure(s) to give my informed consent. If I am a competent adult, I have the right to consent or refuse to consent to any proposed procedure. I understand that I may at any time request more detailed information of any other and less likely problems or complications. I will not be involved in any research or experimental procedure without my full knowledge and consent. I am aware that the practice of medicine is not an exact science and that diagnosis and treatment may involve admission to the hospital in the event of medical need, risks of injury or even death and acknowledge that no guarantee has been made to me as to the results of any examination, procedure or treatment in this facility. I am aware that the nature of the procedure, anticipated results and potential complications cannot always be anticipated with complete accuracy. For this reason, I acknowledge that prior to signing this form I understand this information and I have been given a complete opportunity to ask any and all questions of my physician, which I may wish answered concerning the procedure, its risks and alternative procedures.

IN THE CASE OF A MINOR OR MENTALLY OR PHYSICIALLY INCAPACITATED PATIENT, AUTHORIZATION MUST BE SIGNED BY THE PATIENT'S LEGAL REPRESENTATIVE.

_____ _____
Signature of Patient Date

_____ Reason patient unable to sign: _____
Signature of Legal Representative

_____ _____
Staff/Witness Signature Date

I certify that the patient/parent/guardian or other legally responsible person has been provided information on the risks and hazards, benefits and alternatives to treatment as outlined above, had questions within my area of expertise answered and has given consent.

_____ _____
Physician Signature Date