Northwest Gastroenterology
CLINIC & ENDOSCOPY CENTER

Patient Informed Consent

Procedure(s):

☐ Upper Endoscopy (with possible biopsy, polypectomy, sclerotherapy, cautery, or dilation) is an examination of the esophagus, stomach and duodenum with a flexible scope, which is inserted through the mouth. Forceps or a snare may be inserted through the instrument to cut or burn tissue, polyps, or growths. Cautery may be applied to control bleeding by burning bleeding spots. Medications can be in injected locally to control bleeding or to shrink abnormal vessels. A dilator tube may be passed to stretch narrow areas if needed. Medications may be given in the vein for sedation, stomach and bowel relaxation.

☐ Colonoscopy (with possible biopsy, polypectomy, cautery, or dilation) which is an examination of the entire colon with a flexible scope, which is inserted through the rectum into the colon. Forceps or a snare may be inserted through the instrument to cut or burn tissue, polyps, or growths. Cautery may be applied to control bleeding by burning bleeding spots. Medications can be injected locally. A dilator tube may be passed to stretch narrow areas if needed.

Dr. _____ will perform the above ☒ procedure(s).

Risks of the procedure(s) may include but are not limited to: Mild sore throat and abdominal bloating are common. Rarely, perforation, injury to adjacent organs or tissue, and/or bleeding may occur, requiring surgery or blood transfusion with the attendant surgical risks and risks of blood-borne infection. A local wound infection is possible, but unlikely. Allergic or other reactions to medications may occur. As with any medical procedure there is a small risk of heart complications (such as irregular heart rhythm, angina, or even cardiac arrest) and lung complications (such as aspiration pneumonia) but more so in patients with underlying heart or lung disease. If medication is given in the vein, there is a risk of inflammation of veins, nausea, and a small added risk of heart and lung complication. There is a small risk of overlooking a problem which is present. Alternative procedures or treatments may include but are not limited to: Surgery and Radiology.

The procedure(s), risks and alternatives listed above were explained to me. I have been instructed regarding the risks, benefits, and side effects of the alternatives, including the possible results of not receiving care, treatment, and services. I have had the opportunity to ask questions and all of my questions about the procedure(s), risks and alternatives were answered to my satisfaction. I have been instructed regarding potential problems that might occur during my recuperation and the likelihood of achieving goals. I understand that, during the course of the procedure(s), unforeseen conditions may necessitate additional or different procedures than those listed above or discussed with me. I authorize the physician/credentialed provider and other practitioners to perform such other procedures as are, in their judgment, necessary and appropriate. I acknowledge that no warranty or guarantee was made to me as to the result or cure.

I CONSENT TO THE ABOVE PROCEDURE(S)

_____

(Patient's Signature*) (Date and Time)

_____

(Authorized Consenter's Signature) (Date and Time)

_____

(Relationship to patient) (Printed Name)

_____

(Witness' Signature) [Only required for telephone consent] (Printed Name)

I EXPLAINED THE ABOVE PROCEDURE(S) TO THE PATIENT OR AUTHORIZED CONSENTER

_____ _____

(Physician's/Credentialed Provider's Signature) (Date and Time)