SCOTTSDALE ENDOSCOPY CENTER
PHONE: 480-657-0889 FAX: 480-657-9277

ENDOSCOPY CONSENT/CONSENT FOR EMERGENCY SERVICES/RELEASE OF MEDICAL RECORDS

Direct visualization of the digestive tract or colon, with the use of a lighted instrument, is referred to as an endoscopy. At the time of your examination, the inside lining of the digestive tract or colon will be inspected thoroughly, and possibly photographed. If an abnormality is seen or suspected, a small portion of tissue (biopsy) may be removed for microscopic study, or the lining may be brushed and washed with a solution that can be sent for an analysis of abnormal cells (cytology). Small growths can frequently be completely removed (polypectomy). Occasionally, during the examination, a narrowed portion (stricture) will be stretched to a more normal size (dilation).

RISKS

1) Injury to the lining of the digestive tract or colon by the instrument, which may result in perforation of the wall and leakage into body cavities. If this occurs, surgical operation to close the leak and drain the region is often necessary.
2) Bleeding, if it occurs, is usually a complication of a biopsy, polypectomy, or dilation. Management of this complication may consist only of careful observation, or may require cautery, sclerotherapy, blood transfusion, or surgical operation for control.
3) Other risks include drug reactions and complications, incident to other diseases you may have. You should inform your physician of all your allergic tendencies and medical problems before undergoing the scheduled procedure(s).
4) Colonoscopy: A small percentage of polyps and other lesions can be missed with the colonoscopy test.
5) Esophagogastroduodenoscopy (EGD): Risks include, but are not limited to, bleeding, tearing of the wall of the esophagus, stomach, or intestines; aspiration of fluid from your stomach into your lungs; irritation to gums and lips; and, very rarely, dental damage.

BRIEF DESCRIPTION OF EACH ENDOSCOPIC PROCEDURE:

1) Esophagoscopy: examination of the esophagus from the throat to the entrance of the stomach.
2) Gastroscopy: examination of the stomach, usually combined with esophagoscopy and duodenoscopy.
3) Duodenscopy: examination of the small intestine just beyond the stomach (site of most ulcers); this test is frequently done at the same time as an esophagoscopy and a gastroscopy.
4) Proctoscopy or Sigmoidoscopy: examination of the anus, rectum and low colon (large intestine), usually to a depth of 24 inches.
5) Colonoscopy: examination of all or a portion of the colon, requiring careful preparation of the patients' diet, enemas, and medication. Patients with previous pelvic surgery, or those with extensive diverticulosis may be more prone to complications.
6) Polypectomy: may be performed using a wire loop and electric current or biopsy forceps with or without electrical current to remove small growths that protrude into the colon.

(The above procedures may also require: biopsy, specimen collection, polypectomy, electrical cautery, sclerotherapy or dilation of strictures).

I hereby authorize and permit _____, M.D. to perform upon me the following procedure(s):
☐ Esophagogastroduodenoscopy ☐ Colonoscopy ☐ Sigmoidoscopy ☐ With sedation
with _____, MD☐ / DO☐ / CRNA ☐ for ☐ Assisted Sedation.

I CONFIRM THE FOLLOWING:

1) That my physician has explained to me the nature, purpose, benefits, and possible consequences of each procedure, as well as the risks and complications involved which include but are not limited to: bleeding, perforation, infection, or death;
2) I have read and fully understand this consent form, and signed it only after all questions had been answered to my satisfaction. I understand that no guarantee has been made as to the results of the procedures, and that it may not cure my condition(s).

I HEREBY CONSENT TO:

1) The disposal of any tissues that may be removed during the procedure(s) and;
2) Photographing of the procedure(s) performed for medical purposes.

I hereby authorize The Center to disclose all or part of my medical records to any person or corporation, which is, or may be, liable for all or part of the Facility's charges.

CONSENT FOR EMERGENCY SERVICES/HOSPITAL TRANSFER:

If an emergency should arise during the procedure(s), calling for additional procedures, operations, or medications (including anesthesia and blood transfusions), I authorize my physician to do whatever they deem advisable in my best interest. I also authorize my emergency transfer to the nearest hospital facility, if warranted by my condition. Advance Directives will be honored.

Patient Signature: _____ Date: _____ Time: _____

Physician Signature: _____ Witness: _____

Patient Sticker