NORTH MISSISSIPPI MEDICAL CENTER

TUPELO, MISSISSIPPI

Consent Form for EGD with EUS

STAMP WITH ADDRESSOGRAPH

1. I hereby authorize, Dr._____ ("my physician") and/or other physicians designated by him/her and the employees and staff of North Mississippi Medical Center, to perform an **EGD (Esophagogastroduodenoscopy)** with an **EUS (Endoscopic ultrasound)** upon me, referred to as the "procedure". I understand that my physician will be assisted by other physicians and health care professionals considered necessary in my care. I agree to their participation in my care.

2. My physician has discussed with me the items that are briefly summarized below:

   a. **Procedure**:
   EGD: A procedure where a thin, lighted flexible tube (scope) with small video camera at the end is placed through the mouth and into the esophagus, stomach and first part of the small intestine. The "scope" is slowly withdrawn and the whole area is examined. If any unusual areas are seen then a biopsy (removal of a small tissue sample) may be taken through the "scope" and sent to a pathological lab for testing. Treatment of other lesions may be performed through the "scope" as well. Dilatation (stretching) of narrowed areas may also be performed.

   The EGD is usually done under "moderate sedation", medication to help you relax and many will fall asleep during the test. At the patient's request this procedure can be performed without sedation. After the test is over, your doctor will discuss your findings and his recommendations with you and your family. You will feel the effects of the sedation for a number of hours, so you should not drive or make binding/legal contracts until the following day.

   EUS: This procedure includes the EGD (same as above) but also has an ultrasound attachment to produce sound waves that will allow visual images of the esophagus, stomach, first part of the small intestine and surrounding organs.

   b. **Nature and Purpose of Procedure**:
   EGD: Usually an EGD may be recommended for several reasons. Listed are the various reasons. I have circled the reason(s) that you are having the test:
   i. Abdominal Pain
   ii. Bleeding
   iii. Difficulty Swallowing
   iv. Nausea and Vomiting
   v. Gastroesophageal reflux disease - GERD
   vi. Evaluation for or follow up of ulcers or Tumors/cancer
   vii. Evaluation for or follow up of Barrett's Esophagus
   viii. Removal of a Foreign Body
   ix. Other _____

   EUS: To provide your doctor with more information than other tests by providing detailed images of the GI tract, pancreas and surrounding organs. This can also help determine the spread of cancers in the esophagus, pancreas, stomach and lung. A needle biopsy may also be performed through the scope called a fine needle aspiration (FNA).

   c. **Known Risks of the Procedure**:
   Risks common to any invasive procedure:
   i. Worsening of underlying medical condition which may require medical treatment
   ii. Aspiration of stomach content into the lung which may require further medical treatment
   iii. Neurological changes: coma, stroke which may require medical treatment
   iv. Complications associated with heart and lung disease
   v. Death

   Risks specifically associated with EGD with EUS:
   i. Perforation-tearing a hole in the esophagus, stomach or intestine which may require surgery
   ii. Bleeding which may require blood transfusions and surgery
   iii. Infection which may require medical treatment or surgical drainage
   iv. Drug reaction and/or trouble with sedation which may require medical treatment or termination of the procedure prior to completion
   v. Pancreatitis or inflammation and bruising of the pancreas. This may require hospital care or even surgery.
   vi. Other unpredicted consequences that may occur
   vii. Risks are slightly increased if a needle biopsy if performed.

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Specific risks associated with my medical condition are as follows:

_____

_____

_____

d. **Alternatives to the Procedure**: The alternatives to the EGD with EUS are as follows:
   i. X-ray of stomach–upper GI series, CAT scans, abdominal ultrasound, MRI
   ii. Observation with no test being done
   iii. Consideration for trial medical therapy
   iv. Empiric treatment of the underlying conditions or symptoms

e. **Predicted Outcome (Prognosis) with No Treatment**: The prognosis if the EGD with EUS is not done may include the following:
   i. Incorrect diagnosis
   ii. Progression or worsening of your current illness
   iii. Missed diagnosis of a cancer
   iv. Curable cancer could spread due to lack of a diagnosis
   v. May not be able to treat the underlying problem effectively because the cause or extent or the problem is not known.

f. **Anesthesia**: I have been told that the use of anesthesia adds additional risk to the procedure including respiratory (breathing) problems, drug reactions, paralysis, brain damage and death. Other anesthesia risk include discomfort or injury to the vocal cords, teeth or eyes.

3. Should a complication arise, I therefore authorize my physician, and/or other physicians designated by my physician and the employees and staff of North Mississippi Medical Center, to provide such medical treatment including additional surgery or procedures as are necessary and desirable in the exercise of professional judgement.

4. I appreciate and understand that there are certain risks associated with this procedure and I freely assume these risks. I also understand that there are possible benefits associated with this procedure. However, I understand there is no certainty that I will achieve these benefits. I have been informed and I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the outcome and results of the proposed procedure. I have been told that this procedure carries risks and that some of these risks may be serious.

5. I have had the opportunity to ask questions of my physician and/or physician's associates concerning my condition, and about the procedure, the alternatives and risks to the procedure, and my physician and/or physician associates have answered all questions to my satisfaction.

6. I authorize my physician and/or physician's associates and staff of North Mississippi Medical Center to permit other persons, including but not limited to students, interns, residents and representatives of medical equipment manufacturers to observe the procedure with the understanding that such observation is for the purpose of advancing medical knowledge.

_____
Initial

7. I certify that all blanks requiring insertion of information were completed before I signed this consent form.

8. I have read the two (2) pages of information. I acknowledge that the information I have received, as summarized on this form, is sufficient information for me to understand the risks and benefits of the procedure and to consent to and authorize the procedure described above. This procedure has been explained to me to my satisfaction. Risks, benefits and alternative treatments have been explained to my satisfaction. I understand that the explanations which I have received may not be exhaustive and all inclusive and that more remote risks not discussed may exist. I am signing this form freely and voluntarily indicating my agreement consent and authorization for this procedure.

_____ / _____ _____ / _____
Patient's Signature/Date (Witness to Patient's Signature/Date)

_____ / _____
If Patient is unable to consent, signature of Patient Representative signing and consenting on behalf of Patient. Date

I have explained the above procedure with the risks and benefits of the procedure to the above-named Patient or Patient's Representative. The Patient (Patient Representative) has acknowledged understanding the nature of the procedure with the risks and benefits and has consented to the procedure. I have answered all questions posed to me by the Patient (Patient Representative).

Physician _____ Date: _____