PATIENT CONSENT
ESOPHAGOGASTRODUODENOSCOPY (EGD)

I authorize Dr. Karim Shakoor to perform the procedure: **ESOPHAGOGASTRODUODENOSCOPY (EGD), which has been advised by my physician.**

EGD is a procedure whereby a flexible lighted tube is inserted through the mouth to examine the esophagus, stomach, and upper small intestine. Sedation will be provided, and specimens may be obtained by biopsy or cytology. If needed a narrowing may be stretched, bleeding controlled, or a foreign body removed. If an unsuspected condition is discovered at the time of procedure, authorization is given to perform such treatment as deemed necessary by the doctor and such other persons as are needed to assist him/her. Any tissue removed will be disposed of by the laboratory in accordance with accepted standards.

I understand that potential benefits include better understanding of symptoms/a disease process, ability to obtain tissue or cells for analysis, perform a needed instrumentation or assess prognosis.

I further understand the alternatives include: **Doing Nothing or Upper GI Series X-Rays.** I understand that I have the right to refuse the recommended procedure.

Potential risks of this procedure include:

a. Injury to the digestive tract such as bleeding, perforation(tearing) or infection /or hemorrhage that may require immediate surgery and/or hospitalization, and very rarely can result in death.
b. Medication reaction such as drop in blood pressure, diminished breathing effort, irregular heartbeat or allergic reaction.
c. Aggravation of an existing medical condition

I understand that not every potential risk or complication can be anticipated or included in an informed consent form. ____________ (patient initials)

I understand that there are potential risks, benefits and alternatives associated with having my procedure performed in an ambulatory surgical facility. These risks and benefits include but are not limited to the following: Risks—since the endoscopy center is not an acute care center, should I require emergency services, I would be transferred to the hospital. Benefits: This center may provide more convenient care as well as less exposure to infection. Alternative: The procedure may be performed in the hospital.

I understand that it may be necessary to test the patient's blood while in the Surgery Center to protect against possible transmission of blood-borne diseases such as Hepatitis-B or Acquired Deficiency Syndrome (AIDS). If for example, a Surgery Center employee or physician is stuck by a needle or sustains a scalpel injury, I understand and consent that the patient's as well as the employee's or physician's blood will be tested (as appropriate). I further understand that the blood will not be routinely tested for these diseases and the results of any testing will be kept confidential in accordance with state and federal laws.

I know sedation and/or anesthesia (complete or partial loss of physical sensation) will be needed for the operation or procedure. The risks for sedation include but are not limited to an unconscious state, drop in blood pressure, depressed breathing and in rare cases can be fatal. I also understand that I will not be able to drive a vehicle, operate any power equipment, or sign any legal documents for 24 hours after the sedation. Patient Initial: __________

Photos or specimens taken during a procedure may be used solely for research or education purposes. Patient identification will not be disclosed. Permission to use this information for the aforementioned purposes may be rescinded at any time at the discretion of the patient.

I understand that my physician may have additional personnel in the Procedure Room to observe or assist. Patient Initial: __________

I understand the information presented in this informed consent form and have the opportunity to ask questions and have them answered. I understand that I should not sign this form if all of my questions have not been answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form.

I have read and fully understand the information in this form.

_______________________________________ _____________________ ____________

Patient Signature Date Time

_______________________________________ _____________________ ____________

Witness Signature Date Time

PHYSICIAN DECLARATION: I have explained the contents of this document to the patient and have answered the patient's questions, and to the best of my knowledge, I feel the patient has been adequately informed and has consented to the procedure.

___________________________________ __________________ _____________

Physician's Signature Date Time

This patient is unable to confer consent related to ___________________________

Consent is therefore given by a) verbal, b) phone or c) proxy.

___________________________ __________________________ ___________________

Signature of proxy Relationship to patient Date & Time

_______________________________________ _______________ ____________

Witness Signature Date Time