



INFORMED CONSENT

Principal Risks and Complications of Gastrointestinal Endoscopy

GI endoscopy is generally a low risk procedure, however, complications are possible no matter how careful one is. Your physician will discuss their frequency with you, if you desire, with particular reference to your own procedure.

- **Perforation:** The procedure may result in an injury to the gastrointestinal tract wall with possible leakage of gastrointestinal contents into the body cavity. If this occurs hospital admission and surgery may be required.
- **Bleeding:** Bleeding may occur. Management of this may consist only of careful observation but may require transfusions, endoscopic cautery, or possible surgery.
- **Risks of Sedation:** For your safety your heart rhythm, pulse, BP and oxygen measurement will be monitored. Possible complications of sedation include, but are not limited to, respiratory depression, disturbances of heart rhythm, decreased blood pressure, nausea and vomiting.
- **Medication Phlebitis:** Medications used for sedation may occasionally irritate the vein in which they are injected. This causes a red, painful swelling of the vein and surrounding tissues, which may persist for several weeks.
- **Other Risks:** Include but are not limited to: drug reactions and complications from other diseases you may already have. Instrument failure, infection and death are extremely rare, but remain remote possibilities.

YOU MUST INFORM YOUR PHYSICIAN OF ALL YOUR ALLERGIC TENDENCIES AND MEDICAL PROBLEMS.

Alternative means of therapy include but are not limited to x-ray studies and virtual examinations or surgery. Another option is to choose no diagnostic studies and/or treatment.

DIAGNOSTIC/THERAPEUTIC PROCEDURES

Endoscopic examination and possible biopsy/polypectomy, cautery, injections, and/or dilatation if indicated.

UPPER GI ENDOSCOPY (EGD):	Examination of the esophagus, stomach, and duodenum.
COLONOSCOPY:	Examination of all or the major portion of the colon.
FLEXIBLE SIGMOIDOSCOPY:	Examination of the anus, rectum, and last part of the colon.
ESOPHAGEAL pH CAPSULE:	Attachment of capsule to esophageal wall to monitor pH level over 48 hours.
OTHER:	_____

I certify that I have discussed with my physician and understand the information regarding these procedures. I have been fully informed of the risks and possible complications. I consent to the taking of biopsies and reproduction of any photographs taken in the course of this procedure for professional purposes. The proposed anesthetic plan has been discussed with me by an RN and/or Anesthesia Provider and my attending physician. I understand the procedures involved with their attendant risks, and consent to undergo the proposed anesthetic. I also understand that in the course of the procedure the anesthetic plan may need to be changed.

I hereby authorize and permit: _____ M.D. and his assistant(s) to perform the above procedures and to administer anesthesia as necessary during my procedure(s). If unforeseen condition(s) arise during my procedure(s) calling for additional procedures or medications (including anesthesia and blood transfusions), admission to the hospital or surgery, I further request and authorize him/her to do whatever he/she deems advisable in my interest. 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 results of the procedure(s). There is a possibility of missed lesions, an incomplete procedure, and development of future lesions can occur. The policy of the EndoCentre regarding Advance Directives if an untoward event happens, is to stabilize all patients regardless of Advance Directives. Patients will then be transported to the hospital with a copy, if available, of Advance Directives that will be honored there.

I also understand that The EndoCentre is not responsible for any valuables that I chose to bring with me and I release them from any responsibility for loss or damage of any such valuables or belongings.

Date

Signature of Patient or Legal Guardian

Signature of Physician

Signature of Witness to Patient Signature

Signature of Anesthesia Provider

- The Patient/Legal Guardian has read this form or had it read to him/her.
- The Patient/Legal Guardian states that he/she understands this information.
- The Patient/Legal Guardian has no further questions.



**Pre-Endoscopic Procedure
NURSING ASSESSMENT RECORD**

Time: _____ Procedure/Patient ID Band Verified EGD Bravo Dilatation Colonoscopy Flexible Sigmoidoscopy

Patient Education/Learning needs accessed Verbal
 Brochure Anatomy picture Previous procedure
Verbalized comprehension of patient teaching Yes No

IV site: AC Forearm Wrist Hand
 Other: _____ Right Left
Size & Type: 20 gauge 22 gauge Other: _____
500 cc IVF @ KVO NSS D5W # IV Attempts: _____
IV Placed By _____ N/A

Age	Sex	Ht	Wt	B.P.	P	Resp.	SaO ₂	Temp
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Primary Language English
 _____ Interpreter _____

Abdomen: Soft Firm
 Non-distended Distended
 Non-tender Tender

Evidence of child/elder abuse or domestic violence: No Yes If Yes, Document on Back

Barriers to learning: N/A
Education level _____ Cultural/Religious _____
Physical _____ Emotional _____

Pain (Circle One)
0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
Location: _____
Quality: Sharp Dull

Female: Pregnant? No Yes
Breastfeeding: No Yes
LMP: _____ NA
hCG test: NA Pos Neg

LOC: Alert Anxious
 Oriented Confused
 Follows Commands
 Other _____

Mobility: Normal Assisted
Specify: _____

Psychosocial: Tobacco: _____
Drug use: _____
ETOH Intake: _____

Skin: Warm Pink
 Dry Other _____

Disability: None Hearing Vision
 Other _____

Blood Sugar: _____ Time: _____ NA
Normal fasting 70-105 mg/dL (non-diabetic)

Patient Stated Reason For Admission: _____

Medical History: _____

Medications: _____

Medication / Latex / Food / Dye Allergies: _____

Surgical History: _____

Preparation: NPO Since: _____

- Colyte Phos Soda
- Golytely Mg Citrate
- Dulcolax Enema
- Visicol Half Lytely
- Nulytely Other _____
- N/A

Any problems with anesthesia/conscious sedation in the past? No N/A

Yes explain: _____

Results of bowel prep: liquid formed stool

- clear yellow green brown
- N/A

Advance Directives: If yes, Copy for Chart: If yes, Policy Explained:

No Yes No Yes Yes

Personal Belongings: Dentures / Caps / Crowns / Loose Teeth Removed Secured N/A
 Glasses Hearing Aide Removed Secured N/A Clothing: Stretcher

Responsible Driver / Adult Escort: _____ Location: _____
 Lobby Phone _____ Returning _____

Comments: _____

Nurse's Signature(s): _____ Time Assessment Completed: _____

ANESTHESIA RECORD (Pre-Procedure)

Proposed Procedure									
Diagnosis									
Age	Sex	Ht.	Wt.	B.P.	Pulse rate	Resp.	SaO ₂	Temp	NPO

SYSTEMS REVIEW	PHYSICAL EXAM
<input type="checkbox"/> HEENT _____ RESPIRATORY <input type="checkbox"/> COUGH _____ <input type="checkbox"/> SMOKER _____ <input type="checkbox"/> S.O.B. _____ <input type="checkbox"/> ASTHMA _____ <input type="checkbox"/> ETOH Intake _____ <input type="checkbox"/> Drug Use _____ OTHER _____ _____ _____ LMP _____ PREGNANCY: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A PREGNANCY TEST: <input type="checkbox"/> POS <input type="checkbox"/> NEG <input type="checkbox"/> N/A BREAST FEEDING: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	CARDIOVASCULAR & COAGULATION <input type="checkbox"/> HYPERTENSION _____ <input type="checkbox"/> CHF _____ <input type="checkbox"/> MI _____ <input type="checkbox"/> ANGINA _____ <input type="checkbox"/> ARRHYTHMIA _____ <input type="checkbox"/> OTHER _____ <input type="checkbox"/> ANEMIA _____ <input type="checkbox"/> BLEEDING HX _____ METABOLIC & NEURO-MUSC.-SKEL. <input type="checkbox"/> DIABETES _____ <input type="checkbox"/> HEPATIC _____ <input type="checkbox"/> THYROID _____ <input type="checkbox"/> RENAL _____ <input type="checkbox"/> SEIZURES _____ <input type="checkbox"/> CVA _____ <input type="checkbox"/> OTHER _____
	SENSORIUM: _____ DENTAL: _____ AIRWAY _____ LUNGS _____ HEART _____ LABORATORY HGB _____ K + = _____ Gluc. = _____ EKG _____ OTHER _____ _____ _____

MEDICATIONS: _____ _____ _____	ANESTHESIA PLAN <input type="checkbox"/> M.A.C. <input type="checkbox"/> IVCS	ASA PHYSICAL STATUS <table style="width:100%; text-align: center;"> <tr> <td style="width:33%;">1</td> <td style="width:33%;">2</td> <td style="width:33%;">3</td> </tr> </table> Time _____ Signature of Anesthesia Provider Date	1	2	3
1	2	3			
ALLERGIES: _____ _____					
OPERATIONS: _____ _____					

ANESTHESIA PROBLEMS: YES NO IF YES - EXPLAIN:

POST ANESTHESIA TRANSFER NOTE

NO ANESTHESIA COMPLICATION

APPROVE DISCHARGE

Signature

POST PROCEDURE RECORD

Arrival time: _____

Post Procedure Diagnosis _____ Specimens Sent to Lab Yes No

LOC: <input type="checkbox"/> Awake <input type="checkbox"/> Alert/Oriented <input type="checkbox"/> Drowsy/Arouses to verbal stimuli <input type="checkbox"/> Unresponsive <input type="checkbox"/> Other: _____	Abdomen: <input type="checkbox"/> Soft <input type="checkbox"/> Firm <input type="checkbox"/> Non-tender <input type="checkbox"/> Tender <input type="checkbox"/> Non-Distended <input type="checkbox"/> Distended <input type="checkbox"/> Other: _____	Cautery Site <input type="checkbox"/> R <input type="checkbox"/> L _____ <input type="checkbox"/> N/A <input type="checkbox"/> Normal <input type="checkbox"/> Other: _____ Encouraged to pass flatus (gas) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Rectal tube <input type="checkbox"/> Yes <input type="checkbox"/> No Time in: _____ Time out: _____ <input type="checkbox"/> N/A
Pain: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Location: _____ Quality: <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> See comment		

Time	B/P	P	R	SaO ₂	O ₂	Pain	C Rhythm	Comments	Nurse Signature/Initials

IV Amt. on Adm.	IV Site	IV D/C Time	Tot. RR IV Amt. Infused	
I.V. Site: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Redness <input type="checkbox"/> Swelling				
Nurse: _____				

DISCHARGE ASSESSMENT Pain (Level 0-10) _____

Fully Awake
 Alert/Oriented
 Fluids tolerated
 Ambulatory
 Gait steady
 Via wheelchair

Written discharge instructions reviewed with patient and responsible party by: _____

Patient requested responsible party not be present? Yes No

Verbalized Understanding: Yes No Questions Answered: Yes No N/A

Brochures given: N/A

Colon Polyps & Cancer
 Crohn's Disease
 Esophagitis & Stricture
 Hemorrhoids
 High Fiber
 PUD

Constipation
 Diverticulosis
 Heartburn/Reflux
 Hiatal Hernia
 IBS
 Ulcerative Colitis

Discharge Time: _____ To: _____ Seen by MD & approved for discharge: _____

Responsible Party Time / **M.D. SIGNATURE**

Post Procedure Call Record

Date: _____ Time: _____^{a.m.}/_{p.m.} Spoke with: Patient Family Member _____ Other _____

Fever	Nausea/Vomiting	Pain	Pain Site	Pain Rating	Bleeding	Bleeding Site	MD Notified
_____ <input type="checkbox"/> Yes <input type="checkbox"/> No temp	_____ <input type="checkbox"/> Yes <input type="checkbox"/> No	_____ <input type="checkbox"/> Yes <input type="checkbox"/> No		(0-10)	_____ <input type="checkbox"/> Yes <input type="checkbox"/> No		(date and time)
<input type="checkbox"/> Unable to Contact Patient	Date: _____	Time: _____	Comment: _____				
<input type="checkbox"/> Message Left on Machine	Date: _____	Time: _____					

_____ Chart Reviewed
 _____ Returned to MD
 _____ Final Check
 _____ Clinical Staff Signature
 Initials Initials Initials