UPB, Inc Endoscopy Center
760 Parkside Ave
Brooklyn, New York 11226

INFORMED CONSENT

Patient Name: ______________________ Patient Date of Birth and Age: ______________________
Procedure Date: ______________________ Medical Record Number: ______________________
Physician: ______________________ Primary Physician: ______________________

Explanation of procedure: Endoscopy is a thin flexible tube with a light at the end of the tip which is passed through your swallowing tube (esophagus), stomach and small intestine (duodenum) or into the rectum and large intestine to look at the lining of the gut. During the exam, certain diagnostic or therapeutic interventions may be done. A small pinch of tissue sample may be taken (biopsy). A polyp may be removed (polypectomy). A brushing of mucosal lining may be obtained for evaluation for abnormal cells, or cytology. Fluid may be removed for analysis. Narrowing or strictures may be stretched or dilated. Pictures may be taken of the digestive tract during the procedure.

☐ ***Esophagogastroduodenscopy (EGD):*** Examination of the swallowing tube (esophagus), stomach and small intestine (duodenum) to look for ulcers, tumors, inflammation and areas of bleeding.
☐ ***Colonoscopy:*** Examination of all or a portion of the large intestine requiring careful preparation with diet, laxative and medication to look for abnormal tissue, growth (polyps) or areas of bleeding.
☐ ***Endoscopic Ultrasound (EUS):*** Examination of the swallowing tube (esophagus), stomach and small intestine (duodenum) or into the rectum and large intestine to look at the lining of the gut. Sound waves (ultrasound) are use to examine and create pictures of the digestive tract and internal organs such as the liver, bile ducts and pancreas. This exam may include the removal of a small pinch of tissue (biopsy), passage of a needle under sound wave guidance to take a tissue sample or remove fluid, placement of a drain, and removal of abnormal tissue lining of the intestine.

Risks and complications of gastrointestinal endoscopy: Gastrointestinal endoscopy is generally a low-risk procedure. However, all of the below complications are possible. Your physician will discuss their frequency with you, if you desire, with particular reference to your own indication for gastrointestinal endoscopy.

1. **Perforation**: Passage of the instrument may result in an injury to the gastrointestinal tract wall with possible leakage of gastrointestinal contents into the body cavity. If this occurs, surgery to close the leak and/or drain the region is usually required.
2. **Bleeding:** Bleeding, if it occurs, is usually a complication of biopsy, polypectomy or dilation. Management of this complication may consist only of careful observation, may require transfusions or possibly a surgery.
3. **Medication phlebitis**: Medications used for sedation may irritate the vein in which they are injected. This causes a red, painful swelling of the vein and surrounding tissue. The area could become infected. Discomfort in the area may persist up to several months.
4. **Respiratory depression**: The sedation used for this procedure will occasionally suppress breathing. Assisted breathing may be necessary until the sedation wears off.
5. **Other potential risks**: Including drug reactions and complications from other diseases you may already have. Instrument failure and death are extremely rare, but remain remote possibilities. You must inform your physician if any allergies and medical problems.
6. ***Dental:*** *If you have loose teeth, there is a risk of tooth loss with upper Endoscopy procedures*

The practical alternatives to this procedure: Although gastrointestinal endoscopy is an extremely safe and effective means of examining the gastrointestinal tract, it is not 100% accurate in diagnosis. In a small percentage of cases, a failure to diagnosis or a mis-diagnosis may result. Other diagnostic or therapeutic procedures, such as medical treatment, x-ray and surgery are available. Another option is to choose no diagnostic studies and/or treatment. Your physician will be happy to discuss these options with you.

If I chose not to have the above procedure, my prognosis (future medical condition) is: ☐ Unknown ☐ Poor ☐ Good

Unforeseen procedures: I understand that during the course of the procedure described above, it may be necessary or appropriate to perform additional procedures, which are unforeseen, or not known to be needed at the time this consent is given. I consent to and authorize the persons described herein to make the decisions concerning such procedures. I also consent to and authorize the performance of such additional procedures, as they deem necessary or appropriate.

Specimens: I agree to diagnostic studies, tests, x-ray examinations and any other treatment or courses of treatment relating to the diagnosis or procedures described herein. I consent that any tissues or specimens removed from my body

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in the course of any procedure may be tested or retained for scientific or teaching purposes and then disposed of within the discretion of the physician, facility or other health care provider. I understand that the physician, medical personnel and other assistants will rely on statements about the patient, the patient's medical history and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the procedure which has been explained.

Anesthesia Administration: The anesthesiologist has reviewed the risks of anesthesia with me. I accept these risks and consent to the administration of anesthesia. No guarantee has been made as to the results thereof. I have arranged to have a responsible adult to drive me home. I understand that impairment of full mental alertness may persist for several hours following the administration of anesthesia and I will not making decisions or take part in activities, which depend on full concentration or judgment during this period.

Practice of medicine: I understand the practice of medicine is not an exact science and that no guarantees or assurances have been made to me concerning the results of this procedure.

UPB Endoscopy Center specifics: The benefits and risks of having the procedure at an outpatient facility versus a hospital have been explained to me in general terms and I agree. I am aware that if I have an advance directive it is temporarily suspended while I am a patient at UPB Endoscopy Center, as UPB Endoscopy Center considers all patients undergoing procedures considered eligible for life-sustaining emergency treatments and transfer to a higher level of care. I understand that if my condition requires care that is not within the capabilities of the UPB Endoscopy Center, I will be transferred to an acute care facility.

By signing this form, I agree that the risks, benefits and alternatives to the above procedure have been explained to me, that I have read or had this form read and/or explained to me in general terms, that I fully understand its contents, that I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily. All blanks or statements requiring completion were filled in and all statements I do not approve of were stricken before I signed this form. I also have received additional information, including but not limited to the materials listed below, related to the procedure described herein.

I hereby voluntarily request and consent for ____________________, as my physician, and any other physician(s), and such associates, assistants or other medical personnel involved to perform such procedure(s) described or referred herein.

Do not sign this form until all questions have been answered to your satisfaction.

Patient signature: ____________________ Date: ____________ Time: ____________
Or
Guardian signature: ____________________ Date ____________ Time: ____________

Patient unable to sign because: ____

Witness to signature: ____________________ Date: ____________ Time: ____________

I have informed the patient, explained the procedure in detail, discussed all risks and alternative tests, answered their questions and obtained consent to the procedure listed above:

Physician signature: ____________________ Date: ____________ Time: ____________