

Franklin Medical Group, PC

Digestive Disease Center

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ESOPHAGOGASTRODUODENOSCOPY CONSENT (EGD)

HALO RADIOFREQUENCY ABLATION

This is an explanation of the procedure you are going to have. After you have read this, you will be asked to sign it, giving the doctor permission to perform the test.

This test is named after the three areas of the body to be examined: Esophago (esophagus), gastro (stomach), and duodenum (first part of the small bowel). A flexible fiberoptic instrument called an endoscope is passed through the mouth and the back of the throat into the upper intestinal tract.

Abnormalities suspected by x-ray and other abnormalities too small to be detected by x-ray can all be examined by this test. Biopsies (small tissue samples) of suspicious areas can be taken through the instrument and sent to the laboratory. An alternative would be an abdominal operation.

You will be asked to have nothing to eat or drink after midnight the night before the test. The doctor will tell you whether to take any of your regular medications. When you arrive for the test, the nurse will check your pulse and blood pressure and insert an intravenous line into a vein so that you can receive medications. **IT IS IMPORTANT TO LET THE DOCTOR KNOW IF YOU HAVE ANY ALLERGIES.** Your throat may be sprayed with an unpleasant tasting liquid, which numbs the throat so that you will not gag. Medications will be given through the intravenous line to help relax and sedate you. I also consent to the administration of such anesthetics and sedating medications, which may be necessary for the performance of this operation or procedure, understanding that there are risks associated with anesthesia and sedation. I also consent to stop blood thinners for 5 – 7 days prior to procedure as instructed by the doctor.

The test takes about 15-30 minutes depending on whether or not biopsies are taken. When the endoscope is in place, the doctor will put air through it to open the pathway through the upper intestinal tract. This air may make you feel full and uncomfortable as if you have to burp. If biopsies are performed, a small sample of tissue about the size of the head of a pin will be removed. The area may bleed a small amount but usually heals without problems. Since the lining of the intestinal tract lacks nerve endings, you will not feel the biopsies being taken.

As with any test, there may be complications. We want you to be aware of these possibilities. If bleeding from the site of biopsy or polyp removal is more than usual, cautery may be needed. Rarely, severe, uncontrolled bleeding may require blood transfusions or even surgery. Perforation or a tear in the lining of the throat, esophagus, stomach, or duodenum may occur. This may be managed by simply aspirating the fluid until the tear closes or may require surgical closure. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that there are no guarantees concerning results from this operation or procedure. Inflammation of the vein (phlebitis) may occur from the intravenous line or the medications. This may produce a tender lump, which may last for several weeks to months. This eventually goes away. Allergic reactions, drug reactions, and complications from unrelated diseases such as heart attack or stroke may occur. Other complications include, chest discomfort, sore throat (you may experience a sore throat for 24 hours after the test), difficulty swallowing, low grade fever with chills, dark stools, difficulty breathing, abdominal pain, and nausea & vomiting. Extremely rare is the remote possibility that death may occur.

As soon as possible following the procedure, you will be given fluids and a light snack prior to your discharge. **NO PATIENT RECEIVING SEDATIVE MEDICATION WILL BE ALLOWED TO DRIVE HOME.** You may feel bloated and gassy for several hours after the test because of the air introduced during the test. Any other symptoms should be reported to the doctor immediately.

If you have any questions about this test, they will be answered for you before you sign this consent form and the hospital/outpatient surgical facility consent form. **YOUR DOCTOR WILL DISCUSS YOUR PROCEDURE WITH YOU PRIOR TO YOUR DISCHARGE.**

I UNDERSTAND THE BENEFITS AND POSSIBLE RISKS ASSOCIATED WITH THIS PROCEDURE AND GIVE PERMISSION TO DR. _____ TO PERFORM THE ABOVE TEST.

PRINT PATIENT NAME: _____ **DATE:** _____

PATIENT SIGNATURE: _____ **DATE:** _____

WITNESS SIGNATURE: _____ **DATE:** _____