CENTER FOR DIGESTIVE HEALTH ENDOSCOPY CENTER

ACKNOWLEDGMENT OF INFORMED CONSENT FOR ENDOSCOPIC PROCEDURES

I consent to the following procedure(s):

☐ Colonoscopy with possible Biopsy/Polypectomy/Cautery/Dilation/Banding

☐ Esophagogastroduodenoscopy/Enteroscopy with possible Biopsy/Polypectomy/sclerotherapy/Cautery/Dilation/ Percutaneous Endoscopic Gastrostomy Tube Placement

☐ Esophagogastroduodenoscopy/Enteroscopy with possible Biopsy/Polypectomy/sclerotherapy/Cautery/Dilation/ Percutaneous Endoscopic Gastrostomy Tube Removal

☐ Endoscopic Mucosal Resection

☐ Esophagogastroduodenoscopy with Bravo ☐ Esophagoscopy with Biopsy or Ablation

☐ Flexible Sigmoidoscopy with possible Biopsy/Polypectomy/Sclerotherapy/Cautery/Dilation/Banding

☐ Endoscopic Ultrasound/Esophago-Gastro-Duodenoscopy with possible biopsy/Rectal

☐ Infrared Coagulation (Destruction of Hemorrhoids)

- **A Physician has provided the following information for me:**
  1. The nature and benefits of the proposed procedure/treatments
  2. The consequences of non-treatment
  3. The significant alternative treatments
  4. The possible significant complications of the proposed procedures/treatments

- I voluntarily consent to the procedure with Anesthesia as discussed by my physician. I will have the opportunity to discuss any proposed anesthesia, including its potential risks, benefits and alternatives with my physician. I understand that associates, residents, or assistants may participate in my care.
- I realize that medicine is not an exact science and that all possible outcomes and/or complications cannot be anticipated and that no promises or guarantees have been made to me. I consent to the performance of any additional tests/treatments/procedures, other than those now contemplated, which my physician may consider necessary or advisable in the course of the test/treatment/procedure.
- I understand that photography may be a part of performing the procedure. I consent to photography of the treatment or procedures to be performed for medical, scientific, or educational purpose as determined by The Surgical Centers of Michigan/ Macomb Endoscopy Center, PC, my identity will not be revealed by the pathologist or by the descriptive texts that accompany them.
- I authorize The Surgical Centers of Michigan/Macomb Endoscopy Center, PC, to retain, preserve, photograph, and use for the scientific purposes or to dispose of any pathology specimen or tissue removed during the procedure.
- If any urgent or emergent condition arises during this procedure, calling for medication or treatments, the physician is authorized to take action to resolve the situation.
- I understand that Advance Directives are not honored at this facility.
- I have received the Patient Rights and Responsibilities information prior to my procedure.
- In the event that an employee becomes exposed to my blood and/or body fluids, I agree to provide a sample of my blood for immediate testing
- Personal recording devices are prohibited.

If the patient is unable to consent due to incompetence, the signature of a spouse, next of kin, or other legally authorized person is required. ☐ Documentation provided.

Patient/Legal Guardian Signature: []

Witness Signature: []

Troy Gastroenterology, P.C.

And its Affiliated Covered Entities: Center for Digestive Health, Macomb Endoscopy Center, and Surgical Centers of Michigan

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form you acknowledge receipt of the Notice of Privacy Practices for Troy Gastroenterology and its affiliated covered entities listed above. Our Notice of Privacy Practices provides you with information about how we can use and disclose your protected health information as permitted under federal and state law. We encourage you to read it in full.

In the future, our Notice of Privacy Practices will be provided to you upon your request.

Signature of Patient/Patient Representative: []

Consent for Driver to Be Brought to Recovery

Name of Driver: **Relationship to Patient:**

Driver's Phone #:

☐ **YES**, I hereby consent to have the person listed above brought to Recovery where the Physician and other Clinical Staff may discuss my Treatment and Care and disclose personal medical information.

☐ **NO**, I do not consent to have my driver brought to Recovery. They are here for transportation only.

Signature of Patient/Patient Representative: []

Witness Signature: []

EXPLANATION OF PROCEDURE

Direct visualization of the digestive tract with lighted instruments is referred to as gastrointestinal endoscopy. Your physician has advised you to have this type of examination. The following information is presented to help you understand the reasons for and the possible risks of these procedures. At the time of your examination the lining of the digestive tract will be inspected thoroughly and possibly photographed. For some procedures fluoroscopy/X-ray may be used. If abnormality is seen or suspected, a small portion of tissue (biopsy)/small growth (polyps) may be removed of the lining may be brushed. These samples are sent for laboratory study to determine if abnormal cells are present.

Principal 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 indications for gastrointestinal endoscopy. **YOU MUST ASK YOUR PHYSICIAN IF YOU HAVE ANY UNANSWERED QUESTIONS ABOUT YOUR TEST.**

Due to the COVID-19 outbreak, some procedures that would have normally been scheduled at the hospital are being performed at Macomb Endoscopy Center. If you have any concerns regarding the location of your procedure, please discuss this with your physician.

COVID-19 testing is being provided solely as an infection control measure at our ambulatory surgical centers. A negative test does not indicate absolute absence of infection or inability to infect others. It is possible for this test to give a negative result that is incorrect (false negative) in some people with COVID-19. This means that the patient could possibly still have COVID-19 even though the test is negative. Regardless of the test result, the patient is advised to exercise reasonable precautions as recommended by the Centers for Disease Control (CDC) and to seek medical attention if symptoms develop.

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, transfusions or a surgical operation.

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 for several weeks to months.

4. INFECTION: Infection may occur at intravenous or PEG sites. ERCP may result in infection of the bile duct or blood stream, especially if the bile duct or pancreatic duct is obstructed. Aspiration pneumonia can develop if oral or gastric content enters the bronchial tree. Management is specific to each situation.

5. OTHER RISKS: Include drug reactions and complications from other diseases you may already have. ERCP may result in pancreatitis. Instrument failure and death are extremely rare, but remain remote possibilities. *You must inform your physician of all your allergic tendencies and medical problems*.

6. Possible risks include missing significant neoplasm (tumor), dental injury and sedative complications up to and including death.

7. *Dental injury is not uncommon with anesthesia. Placing a plastic bite block between the teeth may place pressure on the teeth. Please inform us of any pre-existing dental disease, conditions, and dental work, such as caps, crowns, and bridges which increases the susceptibility to dental injury. I understand that these dental risks apply to anesthesia/procedure and the practice will not be responsible for damage.*

Alternatives to Gastrointestinal Endoscopy

Although gastrointestinal endoscopy is an extremely safe and effective means of examining the gastrointestinal tract, it is not 100 percent accurate in diagnosis. In a small percentage of cases a failure of diagnosis or a misdiagnosis 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.

Sedation and Analgesia

Sedation and analgesia describes a state that helps you to relax and minimizes unpleasant sensations while maintaining adequate heart and lung functions.

☐**EGD (Esophagogastroduodenoscopy)/Enteroscopy:** Examination of the esophagus, stomach, duodenum, and small intestine. If active bleeding is found, coagulation by heat may be performed. If polyps are found, they may be removed.

☐**COLONOSCOPY:** Examination of all or a portion of the colon. Older patients and those with extensive diverticulosis or previous pelvic surgery are more prone to complications. Polypectomy (removal of small growths called polyps) is performed, if necessary, by the use of a wire loop and electric current. Colon decompression may be performed if needed.

☐**FLEXIBLE SIGMOIDOSCOPY:** Examination of the anus, rectum and left side of the colon, usually to a depth of 60 cm.

☐**BRAVO ESOPHAGEAL 48 HOUR Ph TEST:** An esophageal pH test measures and records the pH in your esophagus to determine if you have gastroesophageal reflux disease (GERD). The test can also be done to determine the effectiveness of medications or surgical treatment for GERD.

☐**BARRX/HALO ABLATION:** Treatment of Barretts Esophagus using heat energy through a specialized catheter during endoscopy.

☐**IRC (Infrared Coagulation):** A treatment for hemorrhoids by placing a probe above the hemorrhoid exposing the tissue to a burst of infrared light. This coagulates the veins above the hemorrhoid causing it to shrink and recede.

☐**HEMORRHOIDAL BAND LIGATION:** A non-surgical treatment for symptomatic internal hemorrhoids using endoscopic placement of a rubber band placed on the hemorrhoid in the rectum.

☐**EIS (Endoscopic Injection Sclerotherapy):** Injection of a chemical into varices (dilated varicose veins of the esophagus) or a bleeding ulcer to harden the vessel or ulcer to prevent further bleeding. Injection is done by passing a small needle through the endoscope.

☐**ESOPHAGEAL BAND LIGATION:** Endoscopy placement of a rubber band around swollen and bleeding veins in esophagus or stomach to stop the bleeding.

☐**CAPSULE ENDOSCOPY:** A video capsule that contains a miniature color video camera with a light transmitter and batteries to perform a painless examination of your esophagus and small intestine.

☐**GASTROINTESTINAL DILATION:** Dilating tubes or balloons are used to stretch narrow areas of the gastrointestinal tract.

☐**ERCP(Endoscopic Retrograde Cholangiopancreatogram):** Examination of the gall bladder, liver and pancreatic ducts. Areas are visualized through an endoscope with the aid of dye and X-ray. A sphincterotomy (widening of narrow areas) may be done or a stent (tube for drainage) may be inserted. Lithotripsy (stone breakup) or dilation may be done as needed.

☐**PEG (Percutaneous Endoscopic Gastrostomy):** Placement of a feeding tube through the abdominal wall into the stomach. An endoscope is used to examine the area and assist in placement or removal of tube.

☐**EUS (Endoscopic Ultrasound):** Placement of a lighted tube with attached ultrasound into the GI tract to obtain images and information.

☐**EMR (Endoscopic Mucosal Resection):** A procedure where abnormal tissue is removed through a specific resection technique. This carries a small, but increased, risk of bleeding after the procedure and injury to the digestive tract (perforation).

☒ I have received a copy and read the Explanation of Procedure Form.

Sign: []

COVID-19 Risk Informed Consent

I understand that I am opting for a treatment/procedure/surgery that may not be urgent, but is still medically necessary.

I also understand that the novel coronavirus, SARS-CoV-2 ("COVID-19"), has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that my doctor and all the staff at the center are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment/procedure/surgery, and I give my express permission for my doctor and all the staff at the center to proceed with the same.

I understand that, even if I have been tested for COVID-19 and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID-19 after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure/surgery itself.

I have been given the option to defer my treatment/procedure/surgery to a later date, but understand by doing so, may expose me to risk of failure to diagnose or treat a potentially serious condition. I have carefully read and fully understand the above statements, understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, have had the opportunity to ask questions, and I would like to proceed with my treatment/procedure/surgery.

Patient Signature or Person Authorized to Sign for Patient: []