SGC Specialty Gastro Center

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INFORMED CONSENT FOR GI ENDOSCOPY

Patient Name:____ DOB:____________________

GI Endoscopy

Definition: The examination of the inside of the body by using a lighted, flexible instrument called an endoscope. In general, an endoscope is introduced into the body through a natural opening such as the mouth or anus. Although endoscopy can include examination of other organs, the most common endoscopic procedures evaluate the esophagus, stomach and portions of the intestine (Colonoscopy).

Diagnostic Colonoscopy versus Preventative Colonoscopy

The U.S. Preventive Services Task Force suggests a person over the age of 50 (or younger for a patient with a higher risk) should receive a Colonoscopy to screen for possible colorectal cancer. The Affordable Care Act mandates that insurance plans cover a colorectal screening without patient cost sharing (i.e. co-pays, coinsurance or deductibles, etc.). ***Please note that any symptom such as a change in bowel habits, diarrhea, constipation, rectal bleeding or abdominal pain noted prior to the procedure and recorded as a symptom by the physician in your medical record could likely change your benefit from a screening to a diagnostic colonoscopy and cost sharing will likely occur. The physician must report any symptom or diagnosis and cannot alter medical records. Please review your insurance benefits to understand what your coverage will be if the procedure is considered a diagnostic colonoscopy rather than a screening colonoscopy.***

Sedation

Due to sedation, you may remember very little about the procedure(s). Sedation temporarily affects your coordination and reasoning skills so you shouldn't drive, drink alcohol, operate machinery or sign legal documents for 24 hours after the procedure. Due to the symptoms mentioned above, The doctor ewill discuss the results of your examination when you return to the office for your post procedure appointment.

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Complications

Minor side-effects include pain or redness at the IV site, gas or bloating, nausea, vomiting or drowsiness after the procedure. Rarely, discomfort may be felt in the abdomen, throat and/or rectum. These sensations should pass and are minor in nature. If your symptoms persist, please call our office.

The following are rare risks of these procedures but could potentially be life threatening:

- Injury to the lining of the digestive tract resulting in perforation of the colon and leakage into body cavities. If perforation happens, you may require surgery which will result in a hospital stay.
- Bleeding, if it occurs, usually is a complication of the biopsy, polyp removal, dilation or electro-coagulation. This may occur if you take certain medications that thin the blood such as; Coumadin (Warfarin), Lovenox (Enoxaparin), Heparin, Plavix (Clopidogrel), Pradaxa, Xerelto, aspirin products or arthritis medication including Ibuprofen. ***Please be sure to inform our providers and staffs if you take any of these or similar medications.***
- Reactions to the sedative medications given during the procedure may occur although it is uncommon. ***Please notify our providers and our staff if you have any medication allergies or previous unusual reactions to sedatives.***
- Very rarely there can be unforeseen complications that include breathing issues, heart problems, infection, and injury to other internal abdominal organs or even death.
- Occasionally it is not possible to examine the entire colon, which may cause neoplasms (abnormal growths of tissue) to be missed and additional testing may be required.

If any of the above symptoms occur, please contact the office immediately.

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Confirmation

Please initial each line as indication that you have read, understood and received the following:

_____ • The preparation instructions have been reviewed in detail with me and I am in receipt of these instructions. If the preparation is incomplete, another procedure might be required.

_____ • The surgical facility will call you in the afternoon the day before to confirm your procedure. If contact is not made, please call our office before 5:00 p.m.

_____ • I have been made aware that I should contact my insurance company to confirm my financial responsibilities (such as any deductibles and co-pays) including if the colonoscopy is considered diagnostic instead of screening.

_____ • I will make arrangements to have someone drive me home from my procedure because I will be unable to drive due to the sedation.

_____ • If you are unable to make your procedure appointment, please call the office within 24 hours of procedure time. If contact is not made with the office to cancel or reschedule the procedure, you will incur a ***$100 No Show Fee***.

My signature below affirms that I have read and made aware of the complications, and agreed to do the procedure(s).

Patient Name: ____________________________________ DOB: _______________________________

____ __________________________________
Signature of Patient or Responsible Party Date

____ __________________________________
Surgical Coordinator Signature Date

If you have any questions or concerns, please contact our office and we will be happy to assist you.

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