

PROPOSED PROCEDURE

1. Name of Procedure:

EGD with Possible Interventions (Moderate Sedation) (Esophagogastroduodenoscopy (EGD) with Possible Interventions (Moderate Sedation))

2. Condition to be treated:

To examine the esophagus, stomach, and upper intestine for disease or abnormality.

3. Description of the procedure:

This procedure involves using an endoscope to see inside your digestive tract. The endoscope is a thin, flexible tube with a camera on one end. It allows your doctor to see inside your digestive system. The camera will display images on a screen. Your doctor may use air to inflate your organs. This allows your doctor to see better.

This procedure also involves placing you in a state of sedation. Sedation helps you feel relaxed. It may be given together with light anesthesia. Anesthesia causes you to sleep and reduce your response to pain. Your provider will monitor your heart rate, breathing and other vital functions.

You will be given moderate sedation. You will be sedated using medicines. Your healthcare provider may give these by mouth, by inhalation, or by injection. The medicine may be injected into a muscle or into your bloodstream. You will be able to respond and breathe as normal. Your ability to move may be impaired. You will be sleepy and relaxed. Your provider may use a device to help you breathe.

Your doctor will insert the scope through your nose or mouth. Your doctor may spray a numbing medicine into your throat. Your doctor may insert a bite guard to keep you from damaging the scope. An endoscope can be moved through your esophagus (food pipe) and stomach. It can reach as far as the upper part of your small intestine.

Your doctor may do any of the following:

- * Remove growths (such as polyps), foreign bodies, or other abnormalities.
- * Stretch narrowed areas with balloons or other tools.
- * Place a hollow tube to keep a narrow area open. The hollow tube is called a stent.
- * Stop and control bleeding. Your doctor may use an electrical current or other heat source, clips, rubber bands, or injection of medicines.
- * Take images of your digestive system.
- * Treat enlarged veins with rubber bands or injection of medicine(s).
- * Drain a build-up of fluid.
- * Mark certain areas to help locate them later. This is done using special clips or dye.
- * Take a tissue sample (biopsy).

When the procedure is complete, your doctor will remove the scope.

Patient Information

Name: _____

DOB: _____

FMP/SSN: _____

Provider Name: _____

Additional information, including procedure site. Enter NA if not applicable.

4. Risks of the procedure:

- * Bleeding.
- * Bloating.
- * Damage to the teeth, gums, or nearby structures. This may be discovered during the procedure, or later.
- * Pain or discomfort.
- * You may need additional tests or treatment.
- * Your doctor may not be able to make a proper diagnosis.
- * Infection.
- * Lowering of blood pressure. This may lead to decreased blood supply to your body. It may cause dizziness, fainting or heart attack.
- * Reactions to medicine(s) given or used during or after the procedure.
- * Too little sedation. You may experience awareness, pain or discomfort during the procedure.
- * Too much sedation. You may become unconscious. You may experience respiratory suppression. You may need additional medication or treatment.
- * Breakage of teeth or trauma to the gums.
- * Breathing problems. You may need a breathing tube or other treatment.
- * Your doctor may not be able to complete the procedure under moderate sedation.
- * Damage to the esophagus or nearby structures. This may be discovered during the procedure, or later.
- * Damage to the esophagus, stomach, small intestine or nearby structures. This may be discovered during the procedure, or later.

5. Intended results of the procedure:

This procedure may help your doctor find out what is wrong. This may allow your doctor to offer appropriate treatment.

ALTERNATIVES TO PROPOSED PROCEDURE

6. Recognized alternatives to the proposed procedure:

- * Watching and waiting with your doctor.
- * X-ray tests such as barium swallow (UGI series) or virtual colonoscopy. These procedures do not involve therapy, such as biopsies or removal of polyps.
- * Imaging methods such as magnetic imaging (MRI) or ultrasound.
- * EGD without moderate sedation.
- * You may choose not to have this procedure.

7. Risks and benefits associated with the alternatives:

8. Risks associated with not undergoing any treatment or procedure:

If you choose not to have this procedure, your doctor may not be able to find out what is wrong. Your doctor may not be able to offer appropriate treatment.

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9. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of Tripler Army Medical Center.

10. Exceptions to surgery or anesthesia, if any are (if "none", so state): None

11. I request the disposal by the medical facility of any tissues or parts which it may be necessary to remove.

12. I understand that photographs and videos may be taken of this operation, and that they may be viewed by various personnel. I consent to the taking and hard copy and electronic storage of such pictures.

13. **CONSENT FOR BLOOD PRODUCTS:** Is there a reasonable chance that human blood products will be given during procedure?

Patient Information

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DOB _____

FMP/SSN _____

Provider Name: _____

SIGNATURES

(All items in this form must be completed before signing)

14. COUNSELING PROVIDER: I have counseled this patient regarding the condition to be treated, the description of the proposed procedure, the intended and anticipated results and the risks of the proposed procedure, alternative treatments, if any, the risks and benefits of the alternative treatments, and the risks of undergoing no treatment.

(Signature of Counseling Provider)

15. I have been informed of the condition to be treated, the description of the proposed procedure, the intended and anticipated results, and the risks of the proposed procedure, alternative treatments, if any, and the risks and benefits of the alternative treatments of the above named proposed procedure. I have been informed of the risks of undergoing no treatment.

I request the performance of the above-named proposed treatment or procedure and of such additional treatments or procedures as are found to be necessary or desirable, in the judgment of the professional staff, during the course of the operation or procedure. I acknowledge that no guarantees have been made to me concerning the results of the treatment or procedure. I acknowledge the above has been explained to my satisfaction, I have had the opportunity to ask my doctor questions, and my questions have been answered.

(Signature of Patient)

(Date)

16. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I am the parent, legal guardian, or other surrogate decision maker of the above named individual. I request the performance of the above-named proposed treatment or procedure and of such additional treatments or procedures as are found to be necessary or desirable, in the judgment of the professional staff during the course of the operation or procedure. I acknowledge that no guarantees have been made to me concerning the results of the treatment or procedure. I acknowledge the above has been explained to my satisfaction and I have had the opportunity to ask questions and my questions have been answered.

(Signature of Surrogate Decision Maker)

(Relationship)

(Date)

Will procedure(s) be performed outside the operating room? Yes

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Procedure Name: EGD with Possible Interventions (Moderate Sedation) (Esophagogastroduodenoscopy (EGD) with Possible Interventions (Moderate Sedation))
UNIVERSAL PROTOCOL: NON-OR PROCEDURE VERIFICATION CHECKLIST
For use of this form, see MEDCOM Reg 40-54; the proponent agency is MCHO-CL-Q
Used for Procedures Performed Outside of the Operating Room

Universal Protocol Checklist

Pre-procedure verification: Confirmed correct patient, procedure, consent, positioning, side/site, blood products and special equipment (as applicable).

The procedure site was marked (or used alternative marking method. Note: Not required for obvious wound/lesion, midline, single organ procedures, procedures without intended laterality (e.g., endoscopes and coloscopies) or procedures in which there are no predetermined sites of insertion.

A Time-Out was performed: Immediately before the procedure noting the above as well as confirming the patient's position, relevant images and labs, antibiotics, fluids, and safety precautions IAW MEDCOM Reg 40-54.

Team agrees on procedures to be done:

By: _____

And: _____

Date/Time: _____

Instructions for completing to the Non-OR Procedure Verification Checklist.
Conducting the TIME-OUT prior to incision/procedure

By: Should be signed by the licensed team member who performed the TIME-OUT.

And: Should be the name(s) of at least one member of the team present that participated in the TIME-OUT.

Date/Time: The date and time the TIME-OUT occurred.

Patient Information

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FMP/SSN: _____

Provider Name: _____