BRIGHAM AND WOMEN'S HOSPITAL
DANA-FARBER CANCER INSTITUTE
FAULKNER HOSPITAL
Brigham and Women's HealthCare
TEACHING AFFILIATES OF HARVARD MEDICAL SCHOOL

CONSENT FOR PROCEDURE

LN: Ash
FN: Ingrid
MRN: 15015043 DOB: 12/26/1972
CSN: 3233294702 DOS: 1/15/19
LOC: BWHMCPO8D

Use Patient ID Plate

PATIENT MUST BE IDENTIFIED BY
NAME AND MEDICAL RECORD NUMBER

PROCEDURE: **ESOPHAGOGASTRODUODENOSCOPY, +/- BIOPSY/CYTOLOGY, +/- ESOPHAGEAL DILATATION, +/- ENDOSCOPIC ULTRASOUND, +/- PERCUTANEOUS ENDOSCOPIC GASTROSTOMY, +/- TREATMENT FOR BLEEDING, +/- ESOPHAGEAL STENT**

I understand the nature of my condition, the nature of the procedure, and the benefits to be reasonably expected compared with alternative approaches as has been explained to me.

I understand that there is a chance that major risks or complications of the procedure may occur, including (if applicable) but not limited to infection, hemorrhage, drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, brain damage and loss of life. I also understand that with any procedure, there is always the possibility of an unexpected complication, and no guarantees or promises have been made to me concerning the results of any procedure or treatment. I also understand that unexpected findings may compel my surgeon to perform additional or alternate procedures not herein described.

Specific additional risks for this procedure, if applicable, may include, but are not limited to:

- Bleeding
- Perforation (tear in esophagus, stomach or bowel wall)
- Sepsis (infection)
- Pneumonia
- Surgery/transfusion for complications
- Missed lesion

_____ will perform the procedure. The procedure may also involve the participation of resident physicians, fellows and/or physician assistants. My physician will determine when it is necessary for others to participate in my care.

I understand that it is possible that one or more healthcare industry professionals (technical representatives for medical equipment and device companies) may be present during this procedure for advisory purposes only.

I understand that blood or other specimens removed for necessary diagnostic or therapeutic reasons may later be disposed of by the hospital. These materials also may be used by BWH / FH / DFCI, or other academic or commercial entities, for research, educational purposes (including photographing), or other activity, if in furtherance of the Hospital's missions.

Since aspects of this procedure may have educational value, data, video or photographs may be obtained for teaching purposes, presentations at medical/scientific meetings or publications in medical scientific journals. All such recordings used for teaching purposes will be de-identified.

CONSENT FOR THE USE OF BLOOD PRODUCTS: I understand that there is sometimes a need for blood products during the procedure, and that the benefits from receiving blood products outweigh the associated risks. A Blood Transfusion Information Sheet which describes the risks, benefits and alternatives to transfusion is available should I have questions. I have had an opportunity for my questions about blood transfusion to be answered.

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☐ YES _____ (clinician initials) PROCEDURAL SEDATION IS PLANNED TO BE USED AND/OR MAY POTENTIALLY BE USED FOR THIS PROCEDURE; My physician has discussed the use of Procedural Sedation. The risks include but are not limited to slower breathing and low blood pressure that may require treatment, and occasionally incomplete pain relief.

Additional comments (if any):

The above risks and benefits have been explained to me. I have had an opportunity to fully inquire about the risks and benefits of this procedure and its alternatives. All my questions were answered to my satisfaction and I consent to the procedure.

Date_____ Time_____ [redacted]
Signature (Patient / Health Care Agent)

Date 1/15/19 Time 9:30 _____
Signature (Practitioner) M.D.

IF SIGNATURE CANNOT BE OBTAINED, INDICATE REASON IN COMMENTS SECTION