

Medical Record No:

Name:

Birthday:

National Taiwan University Cancer Center

## Upper Endoscopy Instruction and Consent Form (with Intravenous Sedation)

Please read the information thoroughly, await the physician's explanation, and then sign the consent

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### No. **A233** Upper Endoscopy with Intravenous Sedation Instruction Form

The current form provides information on the benefits, risks, and alternative treatment options to the procedure that you are about to receive. We strongly suggest that you read the information carefully. If you have any further questions about the procedure, please do not hesitate to discuss it with your physician thoroughly before signing this document of consent. Your physician will be more than willing to answer any questions you may have.

#### **1. Notes before the exam**

- (1) **Please inform the doctor if you are on anti-coagulation medication, anti-platelet agents, pregnant, allergic to any drugs, or if you have any history of heart disease, hypertension, idiosyncratic, tuberculosis, liver disorders, hepatitis, HIV, or other contagious diseases.**
- (2) Have you had the following history: severe diseases glaucoma benign prostatic hypertrophy  
medication allergies, list name of the medication: \_\_\_\_\_  
heart disease (including arrhythmia) artificial valves pacemaker implant artificial vessels  
lung disorders: \_\_\_\_\_ asthma (**please bring the medication with you**) or  
other diseases, please list: \_\_\_\_\_  
if you are on anti-coagulation medication, aspirin
- (3) Please follow the instructions of the nursing staff for pre-exam preparation. The following medications will be administered:
  - A local anesthetic spray (Xylocaine) to the root of the tongue and an oral anti-flatulent agent (Simethicone). A small number of patients may experience temporary discomfort, e.g. dizziness, nausea, etc.
  - An injection of Butylscopolamine to decrease gastrointestinal mobility to facilitate the exam. Please inform the nursing staff if you have glaucoma or prostatic hypertrophy. In addition, some patients may experience temporary dryness in the mouth and blurred vision.

#### **※ Special instructions:**

- For outpatients, please arrive on time according to the appointment notice. For inpatients and patients from the Emergency Room, please wait to be notified by telephone.
- Please bring the appointment notice sheet (and the computer checkout statement), exam consent form (fully completed and signed), and your Taiwan National Health Insurance card. Please sign your name on the Sedative Consent Form and the Self-Pay Agreement.
- The patient must be accompanied by an adult family member. Otherwise, the procedure will be rescheduled.
- If you have any questions or want to change the date of the appointment, please call the exam room (02-2322-0322#37279) three days before your exam. Our hospital policy only allows you to change your appointment once. If, on the exam day, you choose to undergo the upper endoscopy without sedation your examination will be delayed.
- If you have colonoscopy exam with intravenous sedation on the same day, please follow the instruction for colonoscopy exam with intravenous sedation for preparation.

#### **2. Preparation before the procedure:**

- (1) For a morning exam: Do not have any food or drink after midnight the day before exam. On the day of your exam, please blood pressure medications before 5:00 am and do not take diabetic medications (nor use insulin injection).

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- (2) For an afternoon exam: Please take blood pressure medications before 9:00 am and do not have any food or drink after 5:00 am on the day of the exam. Do not take diabetic medications (nor use insulin injection).
- (3) Please wear loose, comfortable clothing that allows easy access to the arms for injection.
- (4) Please remove any nail polish and do not use lipstick.

### **3. After the procedure:**

- Please rest in the exam area for at least 30 minutes, with the company of a relative or friend. Thereafter, if there is no discomfort, you may leave the hospital after notifying the medical staff.
- To avoid choking, there should be no fluid or food intake for one hour after the procedure. Please follow the doctor's instructions before resume eating.
- To find out the test results, please make an appointment at the clinic the day after the exam. For biopsy results, please return to the clinic one week after the exam.
- Please do not drive following the exam.

### **4. Indications:**

Patients receive an endoscopy of upper GI tract under sedation.

- (1) Test area - upper GI tract includes esophagus, stomach and duodenum.
- (2) Test Purpose - any suspected lesion or illness in the upper GI tract is the indication for this examination.

**5. Benefits:** (With this procedure, the benefits listed below may be achieved. However, the physician cannot guarantee any definite beneficial results. It is up to you to make an informed decision after fully comprehending the benefits and risks.)

- (1) Removal of tissues: a so-called biopsy, to determine the lesion. The physician places a long thin metal forceps through the endoscope, to take out a small tissue specimen for microscopic analysis. Patients usually do not feel the biopsy. Possible complications include bleeding and perforation, but the probability is 0.05-0.1%.
- (2) Polypectomy: an electro-ablation method is used to remove a larger size of polyp for both diagnostic and therapeutic purposes. Possible complications are bleeding or perforation, but the probability of this is less than 0.05-0.2%.
- (3) Hemostasis: a local injection of medication, heater probe, or electrocautery will be used to stop bleeding if necessary.
- (4) Success rate: almost 100% except for patients with low tolerance, unusual anatomy, incomplete preparation (food remains in the stomach), or change of vital signs (e.g. consciousness, heart rate, or blood pressure) during the procedure. If the exam cannot be completed, other exam will be scheduled.

**6. Risks:** (There is no surgical procedure, or medical intervention, that is free of risks. The potential risks listed below are recognized. However, there are certain unexpected risks that are not listed below.)

Endoscopy with sedation has a higher risk compared with endoscopy without sedation. A few patients may suffer from injury to the throat, choking, difficulty breathing, aspiration pneumonia, arrhythmia, perforation, or other complications. Please inform the medical staff if you have cardiopulmonary disorders.

**7. Alternative treatment options:** (The alternative treatment options of the proposed surgical procedure, or medical intervention, are listed as follows. If you decide not to accept the proposed surgical procedure, or medical intervention, there might be some associated risks involved. Please consult your physician before making your the final decision.)

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- (1) Upper GI series
- (2) CT Scan
- (3) angiography (for acute bleeding)
- (4) Red blood cell scan (for chronic bleeding)
- (5) Consequences of not receiving an endoscopy: an accurate diagnosis cannot be made to affect the outcome of the treatment; you will not receive the benefits of this procedure.

**8. Supplemental instructions from the physician; patient's questions and physician's explanations:** (If none, please write "none")

Signature of the Physician: \_\_\_\_\_

Date: \_\_\_\_\_ (MM/DD/YYYY)

### Upper Endoscopy with Intravenous Sedation Consent Form

I (the patient) \_\_\_\_\_, born on \_\_\_\_\_ (MM/DD/YYYY), due to \_\_\_\_\_ require an upper endoscopy (with intravenous sedation). I have discussed the benefits, risks, and alternative treatment options of the proposed exam with the physician. I fully understand all the instructions and explanations from the physician and hereby give consent to the treatment.

I agree  only do the inspection.

to receive the procedure and necessary treatment (e.g. biopsy, polypectomy and hemostasis).

Signature of the Consenting Party: \_\_\_\_\_ Phone: \_\_\_\_\_

Relation to the Patient: self spouse guardians son daughter or others: \_\_\_\_\_

Address : \_\_\_\_\_

I.D. No: \_\_\_\_\_ Date: \_\_\_\_\_ (MM/DD/YYYY)

(1. Witness signatures are not necessary if the consent form is signed by the patient or legal representatives. 2. If the patient is alert but unable to sign and other legal representatives are absent, the patient's fingerprint can be used but two witnesses' signatures are required. 3. If the patient is unable to represent himself or herself and relatives/other legal representatives are absent, witness signatures by a law enforcement officer, fireman, social worker, or volunteer are necessary; witnesses' signatures can also be signed by two qualified doctors under emergency conditions.)

Signature of the Witness: \_\_\_\_\_ Signature of the Witness: \_\_\_\_\_

I.D. No: \_\_\_\_\_ I.D. No: \_\_\_\_\_

Date: \_\_\_\_\_ (MM/DD/YYYY) Date: \_\_\_\_\_ (MM/DD/YYYY)