Gary M. Annunziata, D.O., F.A.C.P

UNITED GASTROENTEROLOGISTS

Anh T. Duong, M.D.

Preparation for EGD and/or PEG Placement

Patient Name- _____

Procedure Date and Time- _____

Please do not take any Aspirin products for four days prior to this procedure, unless instructed by your doctor.

There is nothing to eat, drink, smoke or chew after midnight the night before the procedure.

At _____ proceed directly to the:

- ❑ Mirage Endoscopy Center (Brochure Given)
- ❑ Dolores Hope, First Floor Registration
- ❑ Main Hospital Lobby

We do ask that your family member or friend who will be accompanying you for your procedure remain at the _____ until you are ready to leave.

The doctor will see you following the procedure.

You may take any necessary medications the morning of the procedure (Heart medication, Blood pressure medication) with a tiny sip of water unless otherwise instructed by the office.

***** If your procedure is late in the day, you may have clear liquids until _____. *****

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INFORMED CONSENT FOR GASTROINTESTINAL ENDOSCOPY WITH OR WITHOUT DILATATION. AND/OR PEG PLACEMENT. OR EGD WITH HALO ABLATION.

I understand I have been scheduled for a gastrointestinal endoscopy (also called EGD, Esophagogastroduodenoscopy). The procedure examines the lining of the esophagus, stomach and duodenum to see if there are any abnormalities of the upper digestive tract, using a small, thin, lighted flexible tube. During this procedure the doctor may discover small growths and or inflammation, which will either be removed or biopsied. I understand that with the anesthesia/sedation for this procedure I will not be able to drive the remainder of the day and I should not have plans after the procedure. I understand that **I MUST HAVE A DRIVER** take me home.

If you are having a PEG Placement, it is placement of a feeding tube through the abdominal wall into the stomach. An endoscope is used to examine the area and assist with placement. When necessary the original PEG Tube may be removed or replaced.

If you are having a HALO Ablation, the Halo technology delivers radiofrequency energy in a unique way optimizing the removal of unwanted diseased tissue yet minimizing injury to normal esophageal tissue. Larger areas of Barrett's tissue are treated with the balloon-based Halo Ablation catheter, while smaller focal areas of Barrett's tissue are treated with the endoscope-mounted Halo catheter.

I understand some possible risks and complications of the procedure. Some include but are not limited to:

- Infection
- Bleeding
- Perforation (tearing hole) of the gastrointestinal tract
- Damage to other organs beyond the gastrointestinal tract

I understand that sedation and other medicines given during the procedure have a slight risk of unwanted effects. Some reactions include and are not limited to:

- Allergic reaction
- Vein irritation
- Respiratory and cardiac depression
- Even death

Dental Consent

Dental Injury- We will **NOT** accept liability for any mouth or tooth injury. In all upper endoscopies, protective mouth pieces are used. Despite this, some patients develop injuries to existing teeth or dental implants, bridges, etc. If you have loose teeth or partial dentures risk of injury is greater. I understand any cost due to a mishap will be my responsibility.

Blood Thinner Consent

It is very important you let your physician know of any blood thinning medication you may be on. Being off blood thinning medication increases a risk of having a stroke, heart attack or blood clot. Even if it has been stopped in the past without problems, the risk still exists. After polypectomy, restarting blood thinning medication does increase the risk for bleeding.
Blood thinner medication taken _____.
I understand and accept this risk_____ (initial here).

Regarding Billing

This is to inform you that you may have the possibility of receiving three bills when undergoing this procedure. The bills consist of the physician bill for performing the procedure, a bill from the facility, and if there are biopsies retrieved then you will be subject to a bill from pathology as well.

I have read the above statements, my physician/physician assistant or nurse practitioner have discussed it with me. I understand and accept the risk of the procedure and give my consent to proceed.

Patient Name-_____ **Date** _____

Patient Signature- _____ **Witness**_____

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Anesthesia Waiver

Patient Name- _____

Most patients who undergo endoscopic procedures are generally comfortable and do not recall the procedure with a standard sedation technique called **conscious sedation (CS).** This involves the use of a short acting narcotic and a Valium-like medicine that creates sedation that is generally tolerable and safe. **Conscious sedation** is the standard care for endoscopic procedure.

Although we make every attempt to ensure that you are comfortable during the procedure, we cannot always predict in advance of an endoscopic procedure who is going to experience pain, discomfort, or other reactions to the CS.

There is another type of sedation available called **deep sedation (DS).** Insurance companies traditionally do not pay for this; however, it assures that there is generally no recollection of the procedure. **Deep sedation** is done under the care of an anesthesiologist.

You have the option to request DS in advance of your procedure; however, this cannot be done during the procedure if you experience pain that is not responding to the traditional sedation method.

Therefore, we are asking you to choose deep sedation or conscious sedation.

If you want **DS**, we will arrange to have your procedure done under anesthesia; cost estimates will be provided in this circumstance. Please notify the scheduling office staff.

If you do choose to use a deep sedation technique during your procedure there may be an increased risk of complications related to deep sedation and an increased risk of perforation of the gastrointestinal tract. By signing below, you are agreeing to this increased risk and that you have a copy of this document.

I am **waiving** my option to the deep sedation; I am requesting **conscious sedation**, signed:

_____/_____/_____/_____ Print/Signature/Date/Time

I am **requesting deep sedation** as done by an anesthesiologist and accept the associated risk:

_____/_____/_____/_____ Print/Signature/Date/Time

UNITED
GASTROENTEROLOGISTS

PATIENT MEMORANDUM

TO: OUR PATIENTS

FROM: GARY ANNUNZIATA, D.O., ANH DUONG, M.D.,

SUBJECT: DISCLOSURES

FINANCIAL DISCLOSURE

Gary Annunziata, D.O., Anh Duong, M.D. (Collectively the "Physicians") have ownership interest in United Medical Doctors, Temecula Valley Digestive Disease, a Medical Corporation which owns and operates the clinical pathology laboratory. The Physicians generally refer their clinical pathology laboratory work to the on-site clinical pathology laboratory operated by United Medical Doctors, Temecula Valley Digestive Disease Consultants, a Medical Corporation. You have the right to choose another clinical pathology laboratory for the purpose of having any of your pathology work or assignment performed. If you desire to choose another clinical pathology laboratory to have pathology work or assignment performed please let the office manager or your Physician know.

Acknowledgment of Receipt:

_____ Dated: _____
Patient Name- Please Print

_____
Patient Signature