

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 (Blue map 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 _____.

INFORMED CONSENT FOR GASTROINTESTINAL ENDOSCOPY WITH OR WITHOUT DILATATION AND/OR PEG PLACEMENT

YOU HAVE BEEN SCHEDULED FOR GASTROINTESTINAL ENDOSCOPY (ALSO CALLED EGD, ESOPHAGOGASTRODUODENOSCOPY, OR PANENDOSCOPY). THE PROCEDURE EXAMINES THE LINING OF YOUR ESOPHAGUS, STOMACH AND DUODENUM TO SEE IF THERE ARE ANY ABNORMALITIES OF THE UPPER DIGESTIVE TRACT. THE DOCTOR WILL USE A SMALL, LIGHTED FLEXIBLE TUBE THINNER THAN MOST OF THE FOOD YOU SWALLOW. DURING YOUR PROCEDURE, THE DOCTOR MAY DISCOVER SMALL GROWTHS AND OR INFLAMMATION, WHICH WILL EITHER BE REMOVED OR BIOPSIED.

***** POSSIBLE COMPLICATIONS INVOLVED WITH GASTROINTESTINAL ENDOSCOPY *****

GASTROINTESTINAL ENDOSCOPY IS A GENERALLY LOW RISK PROCEDURE. HOWEVER, ALL OF THE BELOW ARE POSSIBLE. YOUR PHYSICIAN WILL DISCUSS THEIR FREQUENCY WITH YOU, IF YOU DESIRE, WITH PARTICULAR REFERENCE TO YOUR OWN INDICATIONS FOR GASTROINTESTINAL ENDOSCOPY. *YOU MUST ASK YOUR PHYSICIAN IF YOU HAVE ANY UNANSWERED QUESTIONS ABOUT YOUR TEST.*

1. **PERFORATION-** PASSAGE OF THE INSTRUMENT MAY RESULT IN AN INJURY TO THE GASTROINTESTINAL TRACT WALL WITH POSSIBLE LEAKAGE OF GASTROINTESTINAL CONTENTS INTO THE BODY CAVITY. IF THIS OCCURS, SURGERY TO CLOSE THE LEAK AND/OR DRAIN THE AREA IS USUALLY REQUIRED. A SURGERY WILL RESULT IN AT LEAST A WEEK STAY IN THE HOSPITAL WITH AN AVERAGE RECOVERY TIME AT HOME OF AT LEAST A MONTH. PAIN AND LOSS OF CONSORTIUM CAN BE EXPECTED.
2. **BLEEDING-** BLEEDING, IF IT OCCURS, IS USUALLY A COMPLICATION OF A BIOPSY, POLYPECTOMY OR DILATION. MANAGEMENT OF THIS COMPLICATION MAY CONSIST OF CAREFUL OBSERVATION, TRANSFUSION, REPEAT ENDOSCOPY OR A SURGICAL OPERATION.
3. **MEDICATION PHLEBITIS-** MEDICATION USED FOR SEDATION MAY IRRITATE THE VEIN NEAR THE SITE OF INJECTION. PHLEBITIS IS RED, PAINFUL SWELLING OF THE VEIN AND SURROUNDING TISSUE. THE AREA COULD BECOME INFECTED. DISCOMFORT IN THE AREA MAY PERSIST FOR SEVERAL WEEKS TO SEVERAL MONTHS.
4. **INFECTION-** INFECTION MAY OCCUR AT THE INTRAVENOUS OR GASTRIC FEEDING TUBE SITES. LUNG INFECTION IS UNCOMMON AND IS DUE TO VOMIT GOING INTO THE LUNGS. MANAGEMENT IS SPECIFIC TO EACH SITUATION.
5. **OTHER RISKS-** INCLUDES DRUG REACTIONS AND COMPLICATIONS FROM OTHER DISEASES THAT YOU MAY ALREADY HAVE. DEATH IS EXTREMELY RARE, BUT REMAINS A POSSIBILITY. SORE THROAT, HOARSENESS AND POTENTIAL VOCAL CORD DAMAGE ARE ALSO POSSIBLE. YOU MUST INFORM YOUR PHYSICIAN OF ALL YOUR ALLERGIES AND MEDICAL PROBLEMS.
6. **DIAGNOSTIC ERROR-** AN EGD IS THE MOST SENSITIVE AND ACCURATE METHOD TO EVALUATE THE ESOPHAGUS, STOMACH AND DUODENUM. HOWEVER, IT IS POSSIBLE TO MISS A GROWTH OR CANCER IN THE EXAMINED AREA. ANOTHER LIMITATION OF AN EGD IS THAT A SPECIFIC DIAGNOSIS OR SOURCE FOR A PARTICULAR SIGN OR SYMPTOM MAY NOT BE FOUND, EVEN IF THE SOURCE IS IN THE EXAMINED AREA. THE EXAM MAY BE NORMAL IN CERTAIN CASES. IF YOUR SYMPTOMS CONTINUE, FURTHER EVALUATION MAY BE NEEDED. IN THIS SITUATION IT IS YOUR RESPONSIBILITY TO NOTIFY YOUR DOCTOR AND FOLLOW UP FOR FURTHER EVALUATION.
7. **CONSCIOUS SEDATION-** EVERY EFFORT IS MADE TO MAKE YOUR EXAM AS COMFORTABLE AS POSSIBLE. CONTRARY TO POPULAR BELIEF, SOME PEOPLE REMEMBER THE EXAM. THIS IS NOT DUE TO IMPROPER SEDATION PRACTICES. IT IS RELATED TO THE DOCTOR'S NEED TO KNOW WHEN YOU ARE EXPERIENCING PAIN. IN ORDER TO MINIMIZE RISK IN SOME PATIENTS MORE SEDATION CANNOT BE GIVEN DUE TO A LOW BLOOD PRESSURE, OXYGEN LEVEL OR OTHER ABNORMAL VITAL SIGNS. IN ADDITION, PATIENTS AT HIGHER RISK DUE TO OTHER MEDICAL PROBLEMS SUCH AS LUNG DISEASE SOMETIMES CANNOT BE SEDATED TO THE LEVEL OF NOT REMEMBERING. ****** IF YOU HAVE TWO PROCEDURES ON THE SAME DAY, THERE IS A GREATER CHANCE OF WAKING UP DURING THE SECOND PROCEDURE. ******

8. **DENTAL INJURY-** WE WILL NOT ACCEPT LIABILITY FOR ANY MOUTH OR TOOTH INJURY. IN ALL UPPER ENDOCOPIES, 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. ANY COST DUE TO A MISHAP IS THE RESPONSIBILITY OF THE PATIENT.
9. **BLOOD THINNER CONSENT-** I UNDERSTAND THAT STOPPING MY BLOOD THINNING MEDICATION INCREASES A RISK OF A STROKE, HEART ATTACK OR BLOOD CLOT. EVEN IF IT HAS BEEN STOPPED IN THE PAST WITHOUT PROBLEMS, THE RISK STILL EXISTS. AFTER A POLYPECTOMY OR DILATION, RESTARTING MY BLOOD THINNING MEDICATION DOES INCREASE MY RISK FOR BLEEDING. I UNDERSTAND AND ACCEPT THIS RISK. _____ (INITIAL HERE)

*** PLEASE DISCONTINUE THE FOLLOWING MEDICATIONS _____ DAYS PRIOR TO YOUR PROCEDURE:

___ COUMADIN ___ ASPIRIN ___ BABY ASPIRIN ___ ECOTRIN
___ PERSANTINE ___ AGGRENOX ___ PLAVIX
___ OTHER- _____

**** BLOOD THINNING MEDICATION IS OFTEN HELD FOR SEVERAL MORE DAYS FOLLOWING YOUR PROCEDURE****

10. *****ANTIBIOTIC USAGE PRIOR TO SURGICAL PROCEDURE*****

DO YOU REQUIRE ANTIBIOTIC USAGE PRIOR TO ANY SURGICAL OR DENTAL PROCEDURE? ___ YES ___ NO

IF YOU INDICATED YES, WHAT IS THE REASON? - _____

WHAT MEDICATION IS PRESCRIBED? - _____

ALTERNATIVES TO GASTROINTESTINAL ENDOSCOPY

ALTHOUGH GASTROINTESTINAL ENDOSCOPY IS AN EXTREMELY SAFE AND EFFECTIVE MEANS OF EXAMINING THE ESOPHAGUS, IT IS NOT 100% ACCURATE IN DIAGNOSIS. IN A SMALL PERCENTAGE OF CASES, A FAILURE OF DIAGNOSIS OR MISDIAGNOSIS MAY RESULT IN OTHER THERAPEUTIC OR DIAGNOSTIC PROCEDURES, SUCH AS ADDITIONAL MEDICAL TREATMENT, X-RAYS, AND SURGERY. ANOTHER OPTION IS TO CHOOSE NO DIAGNOSTIC STUDIES AND/OR TREATMENT. YOUR PHYSICIAN WILL BE HAPPY TO DISCUSS THESE OPTIONS WITH YOU.

BRIEF DESCRIPTION IF ENDOSCOPIC PROCEDURES

___ **1. EGD (ESOPHAGOGASTRODUODENOSCOPY) -** THIS IS AN EXAMINATION OF THE ESOPHAGUS, STOMACH AND DUODENUM. IF ACTIVE BLEEDING IS FOUND, COAGULATION BY HEAT MAY BE PERFORMED. IF POLYPS OR A FOREIGN BODY ARE FOUND, THEY MAY BE REMOVED. IF NARROWED AREAS ARE FOUND, THEY MAY BE DILATED.

___ **2. GASTROINTESTINAL DILATION-** DILATING TUBES OR BALLOONS ARE USED TO STRETCH NARROW AREAS OF THE GASTROINTESTINAL TRACT.

___ **3. PEG (PERCUTANEOUS ENDOSCOPIC GASTROSTOMY) -** 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.

___ **4. EIS (ENDOSCOPIC INJECTIONS CLEROPATHY) OR VARICEAL BANDING-** THIS IS AN INJECTION OF A CHEMICAL INTO AN ENLARGED ESOPHAGEAL VEIN OR BANDING OF THE VEIN TO PREVENT HEMORRHAGES.

____ 5. ABLATION- ABLATION IS THE GENERAL TERM THAT REFERS TO THE HEATING OF UNWANTED OR DISEASED CELLS TO THE POINT OF CELL DEATH. THIS IS ALSO USED FOR THE CONTROL OF BLEEDING (HEMOSTASIS).

____ 6. 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 CIRCUMFERENTIAL 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 CERTIFY THAT I UNDERSTAND THE INFORMATION REGARDING A GASTROINTESTINAL ENDOSCOPY. I HAVE BEEN FULLY INFORMED OF THE RISKS AND POSSIBLE COMPLICATIONS OF MY PROCEDURE. I HEREBY AUTHORIZE DR. GARY ANNUNZIATA/DR. ANH DUONG AND WHOMEVER HE MAY DESIGNATE AS HIS ASSISTANT (S) TO PERFORM THE FOLLOWING UPON ME:

IF FOR ANY UNFORESEEN CONDITION ARISES DURING THIS PROCEDURE CALLING FOR, IN THE PHYSICIAN'S JUDGEMENT, ADDITIONAL PROCEDURES, TREATMENTS OR OPERATIONS, I AUTHORIZE HE TO DO WHATEVER HE DEEMS ADVISABLE. I AM AWARE THAT THE PRACTICE OF MEDICINE AND SURGERY IS NOT AN EXACT SCIENCE. I ACKNOWLEDGE THAT NO GUARANTIES HAS BEEN MADE TO ME CONCERNING THE RESULT OF THIS PROCEDURE.

PATIENT NAME- PRINT

PATIENT SIGNATURE

TODAY'S DATE

WITNESS

AFTER THE PROCEDURE

1. EXPECT A MILD SORE THROAT LASTING ONE TO TWO DAYS. YOU CAN USE LOZENGES FOR RELIEF.
 2. DO NOT EAT OR DRINK FOR ONE HOUR (YOUR THROAT WILL BE NUMB AND WE DON'T WANT ANYTHING TO GO DOWN THE WRONG "PIPE").
 3. DO NOT DRIVE FOR 24 HOURS AFTER THE PROCEDURE.
- FOLLOWING YOUR PROCEDURE, THE DOCTOR WILL SPEAK TO YOU ABOUT THE FINDINGS. DUE TO THE SEDATION YOU MAY NOT REMEMBER THIS DISCUSSION. IF THERE IS NO BIOPSY TAKEN, YOU WILL BE NOTIFIED BY MAIL OR RECEIVE A PHONE CALL FROM THE OFFICE OF THE EXAM FINDINGS AND TIME OF YOUR NEXT APPOINTMENT. IF YOU DO NOT RECEIVE NOTIFICATION FROM THE OFFICE, IT IS YOUR RESPONSIBILITY TO CONTACT THE OFFICE.
- IF THERE WERE BIOPSIES TAKEN DURING YOUR PROCEDURE, THE OFFICE STAFF WILL CONTACT YOU AT LEAST 72 HOURS AFTER THE PROCEDURE WITH THE RESULTS. IF YOU DO NOT HEAR FROM US, DO NOT ASSUME "NO NEWS IS GOOD NEWS" AND PLEASE CONTACT THE OFFICE.

PATIENT SIGNATURE

BILLING REGARDING THIS PROCEDURE

THIS IS TO INFORM YOU THAT YOU HAVE THE POSSIBILITY OF RECEIVING THREE BILLS WHEN UNDERGOING THIS PROCEDURE. THE BILLS WILL CONSIST OF THE PHYSICIAN BILL FOR PERFORMING THE PROCEDURE (FROM OUR OFFICE), A BILL FROM THE FACILITY THAT THE PROCEDURE IS BEING PERFORMED AT (MIRAGE ENDOSCOPY CENTER OR EISENHOWER MEDICAL CENTER), AND IF THERE ARE BIOPSIES RETRIEVED THEN YOU WILL BE SUBJECT TO A BILL FROM PATHOLOGY.

PATIENT SIGNATURE

I CERTIFY THAT I HAVE RECEIVED A COPY OF THIS ENTIRE CONSENT TODAY.

PATIENT SIGNATURE

DATE

Desert Gastroenterology Consultants

The office of:

Gary M. Annunziata, D.O., F.A.C.P. / Anh T. Duong, M.D.

Jonathan C. Lin, M.D., MPH / Adewale B. Ajumobi, M.D., MBA, F.A.C.P

Patient Name- _____
Anesthesia Waiver

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 in the event that 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

DESERT GASTROENTEROLOGY CONSULTANTS
A MEDICAL CORPORATION

PATIENT MEMORANDUM

TO: OUR PATIENTS

FROM: GARY ANNUNZIATA, D.O., ANH DUONG, M.D.,
JONATHAN C. LIN, M.D., MPH, ADEWALE B. AJUMOBİ M.D

SUBJECT: DISCLOSURES

FINANCIAL DISCLOSURE

Gary Annunziata, D.O., Anh Duong, M.D. and Jonathan C. Lin, M.D., Adewale B. Ajumobi, M.D. (collectively the “Physicians”) have ownership interest in DESERT GASTROENTEROLOGY CONSULTANTS, a Medical Corporation which owns and operates the clinical pathology laboratory located in the Physician’s office. The Physicians generally refer their clinical pathology laboratory work to the on-site clinical pathology laboratory operated by DESERT GASTROENTEROLOGY 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:

Patient Name- Please Print

Dated:_____

Patient Signature