Informed consent to ESOPHAGOGASTRODUODENOSCOPY

I, the undersigned, ...

Born on ...../ ...../ ..... , Resident in.....

Tel. / Email ..... E-mail address .....

Parent/Guardian of the patient .....

I declare that I have been informed in an intelligible, clear and comprehensive manner about the recommended course of action and method of performance of the **ESOPHAGOGASTRODUODENOSCOPY** (EGD) through this document being read out to me and a previous discussion with the operating doctor. EGD contemplates the introduction of a flexible instrument from the mouth to explore the esophagus, stomach and

I CONSENT TO THE PERFORMANCE OF

"Low risk" diagnostic tests and/or therapeutic interventions (as defined in the Italian and European guidelines):

- **HISTOLOGICAL SAMPLES (biopsies)**
- **RESECTION, POLYPECTOMY, REMOVAL of small/medium-sized lesions**

I have been informed that the procedure is associated with some adverse events that can be severe:

- *haemorrhage: <10% for therapeutic procedures;*
- *perforation*: 0.5% for diagnostic tests, <2% *for therapeutic procedures;*
- 0.25% *mortality*.

I have been informed that the clinical condition in the aftermath of the test might be characterised by some complications, in particular emergency surgery and/or blood transfusion.

- **SEDATION and ANALGESIA** aimed at reducing pain/discomfort with the possibility of administering antagonist drugs to obtain an adequate reawakening.

I have been informed that *moderate/deep* sedation is associated with the risk of specific adverse events:

- *allergic reactions (bronchospasm and/or hives);*
- *alteration of the blood pressure, heart rate and rhythm;*
- *respiratory and/or cardiac arrest (0.001-0.003%) and mortality (<0.0003%).*

In case I am put under sedation/analgesia, I have been informed that I can only leave the clinic if accompanied by an adult, and that I am not allowed to drive cars or motor vehicles or perform any activity requiring a normal state of consciousness / vigilance in the following 12 hours.

I agree that, if a state of necessity were to arise during the test, the doctor, at his discretion, might make diagnostic and therapeutic decisions departing from the scheduled ones.

I was given time and opportunity to submit, in this connection, all the questions I deemed appropriate and I received comprehensive answers thereto that I understood fully and was satisfied with.

In accordance with the above as communicated to me and with a fully free judgment on my part,

I CONSENT

- **to the proposed treatment**, including any related and complementary manoeuvre, while being able at any time – through a formal and motivated declaration – to modify such decision;
- **to the processing of personal data**, after having been informed of the legislation currently in force on the confidentiality of personal data, particularly sensitive health-related data, and after having perused Italian Legislative Decree No. 196/2003.

Date.....

Signature of the *patient*/*guardian* _____

DOCTOR'S STATEMENT

I, the undersigned, Dr confirm that the patient has

fully understood the above, including the administrative and medical-legal aspects, and that the recommended approach to the test is appropriate:

Recommended course of action.....

Previous test.....

Comorbidities .....

Family history K.....

Antithrombotic therapy aspirin □ ; clopidogrel □; NAO □..... ..... ; warfarin □
in progress □; suspended □ from no. of days; bridge to LMWH □

Signature of the Doctor..... Signature of the Witness .....

I, the undersigned, having been informed by Dr..... ,

DO NOT CONSENT

to undergo the endoscopic examination, while being aware that my refusal could harm my health although I am not presently in a life-threatening condition. I acknowledge that should my state of health worsen and thereby endanger my life, the healthcare operators will nevertheless take whatever measures might be necessary to cope with and resolve the situation in compliance with applicable laws.

Date.....

Signature of the *patient*/*guardian*