

**UNC HOSPITALS  
CHAPEL HILL, NORTH CAROLINA 27514**

**REQUEST AND AUTHORIZATION FOR  
UPPER GASTROINTESTINAL ENDOSCOPY AND BIOPSY  
MIN #180**

I request and authorize Dr. \_\_\_\_\_ and/or associates or assistants of his/her choice at The University of North Carolina Hospitals to perform an upper gastrointestinal endoscopy and biopsies on \_\_\_\_\_.  
Patient's Name

Authorization is also given for control of bleeding, removal of abnormal growths, and dilation of abnormal areas of narrowing in my digestive tract.

**Description of the Procedure:** The upper gastrointestinal endoscopy will involve the insertion of a long, flexible, video/fiberoptic instrument called an endoscope through my mouth and into my upper digestive tract. The endoscope will allow physicians to view and examine my esophagus, stomach, and duodenum, which is the first part of my small intestine.

If any abnormalities are seen, one or more biopsies may be performed. A biopsy involves the removal of a small sample of tissue through the endoscope, which will be examined by a pathologist. Occasionally, a small brush is used to obtain cells from the digestive tract to look for evidence of infection or cancer, if these are suspected.

Treatment procedures may be performed if upper gastrointestinal endoscopy identifies a source of recent or active bleeding, a growth, or a narrowing in my digestive tract. These procedures may include treating the site of bleeding with an electrocautery, laser, heater probe, injection of agents that cause blood to clot, or placement of small elastic bands onto enlarged veins, and/or removal of food or foreign objects from the digestive tract. An electrocautery is an instrument that directs a high frequency electrical current through an area of tissue.

Electrocautery may also be used to remove growths or polyps in a procedure called a polypectomy.

Narrow areas of the gastrointestinal tract may be stretched by the use of balloons or tapered tubes of various sizes.

Topical anesthetics will be applied to the back of my throat to minimize any discomfort from inserting the endoscope. I understand that sedatives such as midazolam, droperidol, demerol, or morphine will be given by intravenous line to cause relaxation and drowsiness. These medications also may cause a brief period of memory loss and result in my not having a recollection of the procedure. Many patients sleep through the procedure, which typically takes 10-45 minutes.

**Risks:** The following risks have been associated with an upper gastrointestinal endoscopy.

1. Slowing of breathing and abnormal heart rhythms: Intravenous medications may cause a slowing of breathing, and in rare cases may cause breathing to stop. They also may cause lowering of blood pressure and/or abnormal heart rhythms. I will be carefully monitored for changes in my breathing and blood pressure and heart rhythms.

2. Perforation of the digestive tract: A perforation or tear in the digestive tract occurs in 3 per 10,000 procedures. The risk of perforation occurs mainly during procedures performed to treat a site of bleeding or to enlarge a narrowed portion of the digestive tract through dilation. Perforation may be more likely to occur in the presence of a tumor or other abnormality. Perforations are treated with antibiotics and/or surgery.

3. Effects of injection into enlarged veins and/or banding: An injection of blood clotting agents into enlarged veins and/or banding may cause fever, ulcers, serious infection, as well as scarring and narrowing of the esophagus, which may require treatment.

4. Bleeding: Bleeding from the gastrointestinal tract may occur following endoscopy. Excessive bleeding may require a blood transfusion or surgery.

5. Infection: Patients with heart murmurs or artificial heart valves may be given antibiotics before an endoscopy is performed in order to reduce the risk of infection of the heart valves.

6. Aspiration of stomach contents: Aspiration of stomach contents into the lungs occurs rarely in patients undergoing this procedure.

7. Other complications may occur: Patients may rarely experience an unexpected, adverse drug reaction to the medications. Inflammation or infection at the intravenous site, a sore throat, and dental injury are other possible complications of an upper gastrointestinal endoscopy.

8. Death: death has been reported to follow an upper gastrointestinal endoscopy in 7 per 100,000 procedures, most often in patients who are seriously ill prior to the procedure.

**Benefits:** I understand that an upper gastrointestinal endoscopy may identify a cause for symptoms that may not be obtained by x-ray or other diagnostic means. The procedure is generally very safe and is well tolerated by most patients. Treatments performed through the endoscope often carry less risk than surgery.

The purpose of a biopsy is to provide a sample of tissue to examine under the microscope or to study with other tests to make a diagnosis and to provide or guide treatment.

**Alternative options:** I understand that x-rays and surgery are the alternatives to an upper gastrointestinal endoscopy and biopsy.

### **Statement of Voluntary Participation:**

I have read the information contained in this form, and have had sufficient opportunity to discuss my medical condition and treatment with the undersigned physician. All of my questions have been answered to my satisfaction, and I believe that I have been given adequate information

upon which to base an informed consent for the upper gastrointestinal endoscopy, biopsy, and other possible therapeutic procedures.

I am consenting to having an upper gastrointestinal endoscopy, biopsy, and other possible therapeutic procedures performed. I understand that I can withdraw my consent at any point. My consent for this procedure is voluntary.

I understand that during the course of the upper gastrointestinal endoscopy, biopsy, and other possible therapeutic procedures something may arise which may necessitate procedures in addition to or different from those described above. If such unexpected circumstances arise I further request and authorize the performance of additional operations or procedures which may be considered necessary or advisable by the undersigned physician and/or his/her associates or assistants.

I further request the administration of such anesthetics as may be considered necessary, desirable, or advisable by the physician responsible for this service.

I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made concerning the performance, results or interpretation of the endoscopy, biopsy, and other possible therapeutic procedures.

For the purpose of advancing medical education I give my permission for observers to be admitted to the operating room or procedure room, and UNC Hospitals and the UNC School of Medicine staff to make and use any photographic or other illustrations of me for diagnostic, scientific, educational, or research purposes, provided that my identity is not revealed. I further authorize UNC Hospitals and the UNC School of Medicine staff to examine and dispose of any tissues or parts which may be removed and to use them for teaching, educational, or research purposes, provided that my identity is not revealed.

I confirm that I have read this form, or it was read to me, and that all blank spaces were filled in and all inapplicable paragraphs, if any, were stricken before I signed below.

\_\_\_\_\_  
Signature of Patient/Person Authorized to Sign for Patient

Date: \_\_\_\_\_

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Hospital Number

**PHYSICIAN CERTIFICATION**

I hereby certify that the patient has read, or had read to him/her, this form and I have explained the nature, purpose, usual and most frequent risks, benefits, and alternatives to the proposed upper gastrointestinal endoscopy, biopsy, and other possible therapeutic procedures. I have offered to answer questions, and fully answered any questions by the patient about the procedure. I believe that the patient understands this form and what I have explained, and has consented to the proposed endoscopy, biopsy, and other possible therapeutic procedures.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Physician Name

Date: \_\_\_\_\_

**WITNESS CERTIFICATION**

I hereby certify that the patient has acknowledged to me that he/she has requested an upper gastrointestinal endoscopy, biopsy, and other possible therapeutic procedures, has received an explanation of the nature, purpose, benefits, usual and frequent risks and hazards of, and alternatives to the procedure, has had all of his/her questions answered, given his/her consent, and has signed the form above.

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Name

Date: \_\_\_\_\_