CHRISTIANA CARE HEALTH SERVICES

CNSNT

CONSENT FOR GASTROINTESTINAL ENDOSCOPY

Date of procedure: _____ /_____ /_____

I, _____ , request and give consent to _____
(Type or print patient name) (Type or print doctor or practitioner name(s))

to perform the following procedure(s):

☐ **Esophagogastroduodenoscopy (EGD) with possible biopsy, polypectomy, dilation of strictures, treatment for bleeding, removal of foreign bodies.**

Esophagogastroduodenoscopy is an examination using a flexible lighted scope passed through the mouth to visualize the esophagus, stomach and first portion of the small bowel called the duodenum. A small tissue sample may be obtained (biopsy) or growths removed (polypectomy) for microscopic study. If a stricture (a narrowed portion of the digestive tract) is found, dilation may be performed to stretch the area to a more normal size by using tapered tubes (dilators) or expandable balloons. Treatment of active or potential bleeding sites may require cauterizing or injecting the site with substances that help to stop bleeding and/or placement of clips to seal off small blood vessels and/or placement of elastic bands to seal off the bleeding site or abnormally enlarged blood vessels.

☐ **Small Bowel Enteroscopy.**

Examination of the small bowel beyond the duodenum.

☐ **Percutaneous Endoscopic Gastrostomy Tube (PEG) insertion/removal.**

Examination of the esophagus, stomach and duodenum is followed by insertion of a feeding tube into the stomach. The tube is passed through the stomach and abdominal wall by way of a small incision.

☐ **Colonoscopy with possible biopsy, polypectomy, treatment for bleeding.**

Colonoscopy is an examination using a flexible lighted scope passed through the rectum to visualize all or a portion of the colon after preparation with diet, laxatives or medication. A small tissue sample may be obtained (biopsy) for microscopic examination. Polypectomy may be performed using a wire loop or forceps and electric current to remove small growths that protrude into the colon. Treatment of active or potential bleeding sites may require cauterizing or injecting the site with substances that help to stop bleeding and/or placement of clips to seal off small blood vessels.

☐ **Flexible and/or Rigid Sigmoidoscopy with possible biopsy, polypectomy, treatment for bleeding.**

Examination limited to the lower portion of the colon (see colonoscopy above) after bowel preparation or cleansing enemas. In general, a sigmoid exam does not require sedation.

☐ **Endoscopic Retrograde Cannulation of the Common Bile and Pancreatic Ducts (ERCP) with possible sphincterotomy, stent placement, removal of duct stones, dilation of strictures, and biopsy**.

This procedure involves passage of a specialized endoscope through the mouth to the level of the duodenum. A small catheter tube is inserted into the bile and/or pancreatic duct to allow injection of dye for X-ray examination of the ducts. Sphincterotomy (an incision made with an electrocautery wire passed through the scope to widen the biliary and/or pancreatic sphincter muscle) may be required to remove duct stones, biopsy suspected abnormalities, or place stents to treat obstructed or leaking ducts.

☐ **Endoscopic Ultrasound (EUS) with possible fine needle aspiration**.

A specialized ultrasound endoscope is passed through the mouth to the level of the esophagus, stomach and/or duodenum to allow an internal ultrasound examination of the walls of the upper digestive tract and surrounding organs, blood vessels and lymph nodes. Biopsy and fluid aspiration may be obtained of suspected abnormalities by penetrating the affected tissue with a needle to remove cells and fluid for microscopic analysis.

☐ **Other Procedure(s)** (describe and list site): _____

_____

The benefits, risks, complications, and alternatives to the above procedure(s) have been explained to me. I have been informed that the possible risks of these procedures include, but are not limited to the following principle risks:

1. Injury to the digestive tract by an instrument which may result in perforation of the bowel wall with leakage of intestinal juices into body cavities; if this occurs, surgery to close the leak and/or drain the region, with possible colostomy, may be necessary.
2. Bleeding which, if it occurs, is usually a complication of biopsy, polypectomy, or dilation. Management of this complication may consist only in careful observation or may require transfusion or possibly a surgical operation for control.
3. Problems from intravenous medications, sedation, and analgesia. These include, but are not limited to, adverse drug reactions, over sedation, breathing problems, allergic reactions, all of which could result in emergency resuscitative measures.
4. For ERCP and EUS, additional risks include infection and pancreatitis - a potentially serious condition caused by inflammation of the pancreas.
5. Missed Abnormalities – Gastrointestinal endoscopy is not 100% sensitive and abnormalities can exist and not be seen even though a full and thorough exam is performed.
6. Other risks include infection, complications from other associated diseases such as stroke or heart attack, and even death.

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I understand that all of these complications, and others, are possible, but occur with a very low frequency. In order to minimize potential problems, I have informed the physician of all my allergic tendencies and medical problems.

I understand that the procedure(s) will be performed at Christiana Care by and under supervision of my doctor or practitioner. My doctor or practitioner may use the services of other doctors or practitioners, or members of the resident staff as he or she deems necessary or advisable.

I authorize my doctor or practitioner and his or her associates and assistants to perform such additional procedures, which in their judgment are necessary and appropriate to carry out my diagnosis or treatment.

I authorize the hospital to retain, photograph, preserve and use for scientific, teaching purposes, or to make other dispositions of, at their convenience, any specimens, tissues, or parts taken from my body during the course of this operation.

I consent to observers in accordance with hospital policy. I consent to a healthcare industry representative being present during the procedure to provide technical assistance or to perform calibration of equipment. I consent to photography or video taping of my surgical procedure for educational purposes, provided my identity remains anonymous and confidential.

I consent to the administration of sedation or analgesia during my procedure. The risks, benefits, and alternatives to receiving sedation or analgesia have been explained to me.

If anesthesia is required, I consent to the administration of anesthesia by an anesthesia provider. I also consent to the use of non-invasive and invasive monitoring techniques as deemed necessary. I understand that anesthesia involves risks that are in addition to those resulting from the operation itself including, but not limited to, dental injury, hoarseness, vocal cord injury, infection, nerve injury, corneal abrasion, seizures, heart attack, stroke and even death.

If applicable, I consent to the use of fluoroscopy. I understand that prolonged exposure to fluoroscopy may result in skin reactions, such as redness, irritation or a burn.

Please initial one of the following statements (females 55 years and under):

_____ To the best of my knowledge I am not pregnant _____ I believe I am pregnant or could be pregnant.

I certify that I have read and understand the above consent statements. In addition, I have been offered the opportunity to ask my doctor or practitioner any questions I have regarding the procedure(s) to be performed and they have been answered to my satisfaction. I acknowledge that I have been given no guarantee or assurance as to the results that may be obtained from the procedure(s).

Signature of Patient or Decision Maker	Date	Time	Doctor or Practitioner Signature/Title	Date	Time
	___/___/___			___/___/___	

Relationship to Patient

Doctor or Practitioner Print Name or ID#

Witness Signature ___/___/___ Time

Witness Print Name

Telephone Consent:

Name of person providing consent

Relationship to Patient if Decision Maker

Witness Signature	Date	Time	Witness Signature	Date	Time
	___/___/___			___/___/___	

Witness Print Name

Witness Print Name

Interpretation: The information presented orally to the ☐ patient ☐ representative ☐ decision maker was interpreted into (language): _____ . The person for whom the information was interpreted stated s/he understood the interpretation.

Interpreter Name

Agency and ID# (if applicable)

Staff Signature/Title	Print Name or ID#	Date	Time
		____/____/____	

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CHRISTIANA CARE HEALTH SERVICES

CNSNT

Neonatal Intensive Care Unit (NICU)

CONSENT FOR ADMISSION, MEDICAL TREATMENT AND PROCEDURES

1. I understand that my newborn, _____ , has been admitted to the Neonatal Intensive Care Unit (NICU) at Christiana Care and that my newborn needs intensive care.
2. I hereby authorize the NICU staff to provide medical care to my newborn. I understand that intensive care includes monitoring of blood pressure, heart action, rate of breathing, and blood studies and that these procedures assist in determining the severity of the condition to aid in further therapy.
3. I have received the NICU procedure description/information booklet. As appropriate, the physician or his/her designee will provide supplemental information regarding procedures when they are performed.

   Received booklet: _____ (parent/guardian initials)
4. I authorize procedures and therapies commonly in use in the NICU to be done on my newborn as physicians in the exercise of their professional judgement deem necessary.

   Therapies commonly in use include:
   - Bladder catheterization
   - Phototherapy
   - Respiratory therapy
   - Oxygen treatment
   - Insertion of feeding tube into the stomach

   Procedures commonly performed include (described in the NICU procedure description/information booklet):
   - Endotracheal intubation
   - Catheter placement into artery or vein
   - Emergency evacuation of pneumothorax
   - Lumbar puncture
   - Chest tube placement
5. I understand that complications may arise as a result of the therapy required to treat my newborn's condition. Complications may include but are not limited to the following (as described in the NICU procedure description/information booklet):
   - Injury to lungs
   - Injury to intestines or other structures
   - Eye injury
   - Brain injury
   - Infection
   - Death
   - Blood clots
   - Perforation or damage to blood vessels
6. I understand that the planned hospital course may include the use of laboratory tests, X-rays, physical therapy, occupational therapy, and other studies consistent with the type of care normally provided in a NICU.
7. I understand that the procedure(s) will be performed at Christiana Care by and under supervision of my newborn's physician or practitioner. My newborn's physician or practitioner may use the services of other physicians or practitioners, or members of the resident staff as he or she deems necessary or advisable.
8. I certify that I have read the above consent statements. In addition, I have been offered the opportunity to ask my newborn's physician or practitioner any questions I have regarding the procedure(s) to be performed and they have been answered to my satisfaction. I acknowledge that I have been given no guarantee or assurance as to the results that may be obtained from the procedure(s).

Physician/Practitioner: I have discussed the information described above with the parent/guardian whose signature appears on this document. I have attempted to answer all questions asked by such person. It is my opinion that the parent/guardian understands the matter discussed.

_____ Physician or Practitioner Signature/Title	_____ Physician/Practitioner Print Name or ID#	____/____/____ Date	_____ Time
_____ Signature of Parent/Guardian	_____ Relationship to Newborn	____/____/____ Date	_____ Time
_____ Witness Signature	_____ Witness Print Name	____/____/____ Date	_____ Time

CHRISTIANA CARE
HEALTH SERVICES

Neonatal Intensive Care Unit (NICU)

CONSENT FOR ADMISSION, MEDICAL TREATMENT AND PROCEDURES

Telephone Consent:

_____ Name of person providing consent	_____ Relationship to Newborn
_____ Witness Signature ____/____/____ Date _____ Time	_____ Witness Signature ____/____/____ Date _____ Time
_____ Witness Print Name	_____ Witness Print Name

Interpretation: The information presented orally to the ☐ patient ☐ representative ☐ decision maker was interpreted into (language): _____ . The person for whom the information was interpreted stated s/he understood the interpretation.

_____ Interpreter Name	_____ Agency and ID# (if applicable)

_____ Staff Signature/Title _____ Print Name or ID# ____/____/____ Date _____ Time

CHRISTIANA CARE HEALTH SERVICES

CNSNT

CONSENT FOR PROCEDURES IN THE INTENSIVE CARE UNIT (ICU)

Purpose: To provide information and consent for routine procedures within an ICU setting (except the Special Care Nursery).

I have been admitted to an intensive care unit of Christiana Care Health Services.

I understand that intensive care includes use of specialized machines and devices called monitors to frequently check the heartbeat, blood pressure and breathing. Mechanical ventilators are machines that help patients breathe and they may be used to provide care.

I acknowledge that patients in the ICU often undergo a variety of procedures. These procedures may include tests to help determine diagnosis or treatments to relieve symptoms.

I authorize and consent to treatments and procedures commonly in use in intensive care units to be performed on me, as my ICU physicians in the exercise of their professional judgment consider necessary or advisable for my diagnosis and treatment. Procedures and treatment may include but are not limited to the following: X-rays, blood tests, the placement of catheters (thin tubes) into arteries and main veins, lumbar puncture (needle in back to collect fluid surrounding spinal cord), bladder catheterization (draining urine from the bladder through a tube), endotracheal intubation (insertion of a tube in the windpipe to aid in breathing), oxygen treatment, respiratory therapy (assisting breathing with a machine), chest tube insertion (a catheter inserted into the chest to treat a collapsed lung), bronchoscopy for suction (insertion of a tube through windpipe to extract secretions) and insertion of feeding tubes into the stomach.

I understand that complications may occur as a result of the therapy required to treat my condition. Complications may include but are not limited to the following: blood clots (which may cause damage to an organ including bleeding in the brain); perforation or damage to blood vessels, lungs, intestines or other structures. Other complications including infection resulting in death and death may occur.

I certify that I have read and understand the above consent statements. In addition, I have been offered the opportunity to ask my doctor or practitioner any questions I have regarding the procedure(s) to be performed and they have been answered to my satisfaction. I acknowledge that I have been given no guarantee or assurance as to the results that may be obtained from the procedure(s).

Signature of Patient or Decision Maker	Date ___/___/___	Time	Doctor or Practitioner Signature/Title	Date ___/___/___	Time
Relationship to Patient			Doctor or Practitioner Print Name or ID#		
Witness Signature	Date ___/___/___	Time			
Witness Print Name					

Telephone Consent:

Name of person providing consent			Relationship to Patient if Decision Maker		
Witness Signature	Date ___/___/___	Time	Witness Signature	Date ___/___/___	Time
Witness Print Name			Witness Print Name		

Interpretation: The information presented orally to the ☐ patient ☐ representative ☐ decision maker was interpreted into (language): _____ . The person for whom the information was interpreted stated s/he understood the interpretation.

Interpreter Name	Agency and ID# (if applicable)		
Staff Signature/Title	Print Name or ID#	Date ____/____/____	Time