MEDICAL RECORD	INFORMED CONSENT FOR PERFORMANCE OF PROCEDURE and REQUEST FOR SEDATION/ANESTHESIA

1. Condition to be treated: Esophagogastroduodenoscopy (EGD) with placement of Bravo pH capsule for the purpose of measuring acid in the esophagus.

PROPOSED PROCEDURE

2. Description of the procedure: A flexible scope is inserted in the mouth (EGD) to inspect the esophagus, stomach, & duodenum, usually under sedation with Versed and Fentanyl.
A capsule is placed in the lower esophagus to measure the amount of acid reflux.

3. Risks of the procedure: Inability to complete procedure, tearing tissue, bleeding, infection, inhalation of gastric contents, allergic reaction, IV site irritation, capsule failure, failure of capsule to release, unstable vital signs, depressed breathing, cardiac arrest and death.

4. Intended results of the procedure: visualize the upper GI tract with a scope and identify problems. Measure and record the number of reflux episodes over a 24 – 48 hour period. These problems can then be appropriately addressed.

ALTERNATIVES TO PROPOSED PROCEDURE

5. Recognized alternatives to the proposed procedure: 24 hour pH probe inserted through the nose.

6. Risks and benefits associated with the alternatives: Risks are nose bleed, sore throat, perforation, pneumonia, aspiration, arrhythmia, improper placement. Benefits: no sedation required.

7. Risks associated with not undergoing any treatment or procedure: Worsening or continued symptoms of undiagnosed reflux.

8. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of Tripler Army Medical Center.

9. Exceptions to surgery or anesthesia, if any are: _____ _____ None
(If "none", so state)

10. I request the disposal by the medical facility of any tissues or parts which it may be necessary to remove.

11. I understand that photographs and videos may be taken of this operation, and that they may be viewed by various personnel. I consent to the taking and hard copy and electronic storage of such pictures.

12. COUNSELING PROVIDER: I have counseled this patient regarding the condition to be treated, the description of the proposed procedure, the intended and anticipated results and the risks of the proposed procedure, alternative treatments, if any, the risks and benefits of the alternative treatments, and the risks of undergoing no treatment.

_____
Signature of Counseling Physician/ Dentist

ENT'S IDENTIFICATION (For typed or written entries, give: Name –last, first, middle, ID no. (SSN or other); hospital or medical

Medical Record

SIGNATURES

(All items in this form must be completed before signing)

13. I have been informed of the condition to be treated, the description of the proposed procedure, the intended and anticipated results, and the risks of the proposed procedure, alternative treatments, if any, and the risks and benefits of the alternative treatments of the above named proposed procedure. I have been informed of the risks of undergoing no treatment.

I request the performance of the above-named proposed treatment or procedure and of such additional treatments or procedures as are found to be necessary or desirable, in the judgment of the professional staff, during the course of the operation or procedure. I acknowledge that no guarantees have been made to me concerning the results of the treatment or procedure. I acknowledge the above has been explained to my satisfaction, I have had the opportunity to ask my doctor questions, and my questions have been answered.

Signature of Patient *(Date / Time)*

14. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I am the parent, legal guardian, or other surrogate decision maker of the above named individual. I request the performance of the above-named proposed treatment or procedure and of such additional treatments or procedures as are found to be necessary or desirable, in the judgment of the professional staff during the course of the operation or procedure. I acknowledge that no guarantees have been made to me concerning the results of the treatment or procedure. I acknowledge the above has been explained to my satisfaction and I have had the opportunity to ask questions and my questions have been answered.

Signature of Surrogate Decision Maker *(Date/Time)* *Relationship*

Universal Protocol Checklist

Pre-procedure verification confirmed correct patient, procedure, consent, positioning, side/site, blood products and special equipment (as applicable).

The procedure site was maked (or used alternate marking method). Note: not required for obvious wound/lesion, midline, single organ procedures, procedures without intended laterality (e.g., endoscopes and colposopies) or procedures in which there are no predetermined sites of insertion.

A Time-Out was performed immediately before the procedure noting the above as well as confirming the patient's position, relevant images and labs, antibiotics, fluids and safety precautions IAW MEDCIM Reg 40-54.

Team agrees on procedures to be done:

By:

And:

Date/Time:

ENT'S IDENTIFICATION (For typed or written entries, give: Name –last, first, middle, ID no. (SSN or other); hospital or medical

Medical Record

Bravo Patient Diary

Date/Start Time _____ Date/End Time _____ On/Off Meds since: _____

Patient _____ Indications for Procedure: _____

The purpose of the bravo pH capsule is to monitor the Esophagus for reflux. We recommend that you keep the receiver with you at all times.

If you take a shower, keep it outside the shower stall. DO NOT GET THE RECEIVER WET.

The three symptom buttons on the receiver are for Heartburn, Regurgitation, and Chest Pain.
***Press the corresponding button when you have a symptom.
Write the time when you start a meal and when you end a meal in the Diary and what you eat.
Write the time when you lie down, and when you get up in the Diary.
If the receiver loses the signal it will beep for approximately 30 seconds. You will see a C1 or C2 error flashing on the screen
***where the time is located. You need to assure transmitter is within 3 feet to stop error.

SYMPTOM BUTTONS	Press For:	Heartburn 	Regurgitation 	Chest Pain 

Enter Times

Date	Meal Starts	Meal Ends	Food Eaten