

**ARAPAHOE GASTROENTEROLOGY**  
**ARAPAHOE ENDOSCOPY CENTER**

**INFORMED CONSENT FOR UPPER ENDOSCOPY**

1.) I, \_\_\_\_\_ authorize  
Dr. \_\_\_\_\_ and any assistant(s) he/she  
deems necessary to perform: Upper Gastrointestinal Endoscopy to include biopsy with  
possible dilatation of stricture, coagulation/injection therapy of blood vessels or tissue,  
and \_\_\_\_\_.

2.) I understand this procedure involves the following: Passage of digital optic instrument to  
allow the physician to visualize the esophagus, stomach and upper small intestine. Sedation  
and pain relieving medication(s) may be given to minimize discomfort and relax me for the  
procedure. These medications may cause localized irritation and/or a drug reaction may  
occur.

3.) **RISKS:** Possible complications of this procedure include but are not limited to: Bleeding,  
infection or perforation of the esophagus, stomach or small intestines. These complications  
(estimated at 1 per 10,000 procedures), should they occur may require surgery, hospitaliza-  
tion and/or a transfusion.

Other risks which can be serious and possibly fatal include: difficulty breathing, heart attack,  
stroke or aspiration. These risks are extremely rare but may occur.

4.) I understand that there are no guarantees regarding the results of this procedure. Alternatives  
are: \_\_\_\_\_.

5.) I have read and fully understand this consent form, and understand I should not sign this  
form if all items, including all of my questions, have not been explained or answered to my  
satisfaction or if I do not understand any of the terms or words contained in this consent  
form. **IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE  
PROPOSED PROCEDURE OR TREATMENT, ASK YOUR PHYSICIAN NOW,  
BEFORE SIGNING THIS CONSENT FORM. DO NOT SIGN UNLESS YOU HAVE  
READ AND THOROUGHLY UNDERSTAND THIS FORM.**

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
**Patient/Responsible Party**

\_\_\_\_\_  
**Date/Time**

6.) **PHYSICIAN DECLARATION:** I have explained the contents of this document to the  
patient and have answered all the patients' questions. To the best of my knowledge, I feel the  
patient has been adequately informed and has consented.

\_\_\_\_\_  
**Physician's Signature**

\_\_\_\_\_  
**Date/Time**