Massachusetts General Hospital Interventional Endoscopy

Thank you for allowing us to participate in your care!

Procedure Information

Scheduled Procedure: _____

Patient Name: _____

Date: _____

You have a _____ procedure. Please arrive at _____

Location: MGH Endoscopy Unit, 4th Floor of the Blake Building

Physician and Phone Number: _____

*It is very important that you keep this appointment. If you must cancel, please do so at least **5 business days in advance**. If you have any questions or concerns, please contact us.*

Important Pre-Procedure Information

What to Bring to Your Exam

**** Please refer to the day of procedure instructions attached with your prep for important covid pre-procedural related inquiries.***

- ☐ For your safety, please arrange for an adult escort to take you home following your procedure. **You will not be permitted to drive or arrange ride share/taxi services. If you do not have an adult escort, hospital policy requires us to cancel and reschedule your procedure.**
- ☐ Name and phone number of your escort if they cannot be with you when you check in. They should be available to pick you up within 30 minutes of being called.
- ☐ A SAMPLE copy of the **MGH Patient Consent to Procedure form** (see last page) is included in this packet for your review. If you are unable to consent on the day of your exam, a signed Health Care Proxy Form must be provided or your Proxy must be present to state consent on your behalf. Your Proxy can also state consent over the phone by calling our office within 30 days of the exam. **If consent is not provided, hospital policy requires us to cancel and reschedule your procedure.**
- ☐ Please note that MGH policy requires that women, ages 11-55 years old, have a pregnancy test prior to having any endoscopic procedure. When you arrive for your procedure, a registered nurse will screen you for the test and if needed, request that you provide a urine sample.
- ☐ Photo identification
- ☐ Updated medication list
- ☐ Do not wear jewelry other than wedding rings.

Medications

- ☐ **If you have diabetes** and are taking Canagliflozin (Invokana), Canagliflozin and Metformin (Invokamet), Dapagliflozin (Farxiga), Xigduo XR Dapagliflozin and Metformin extended-release, or Empagliflozin (Jardiance), please stop it at least three days before your colonoscopy. If you are taking ertugliflozin (Steglatro, Stegujan, or Segluromet), please stop it at least four days before your scheduled colonoscopy. Make sure to contact your primary care physician or diabetes doctor about the suggested changes above and get their guidance as well.
- ☐ If you take insulin, we usually recommend you take ½ your normal dose the day of your exam. We will check your blood sugar.

☐ **If you take blood thinners** (Coumadin, Plavix, Pradaxa, Lovenox, etc.) we recommend you continue unless you have specifically been asked to stop by the GI physician performing your exam. **Please contact your cardiologist or prescribing physician to confirm blood thinner instructions.**

Procedure Preparation Instructions

Day of Your Procedure

- ☐ If you have a **MORNING** procedure, do not eat or drink anything after midnight on the night before the procedure.
- ☐ If you have an **AFTERNOON** procedure, you may have a clear liquid breakfast. Clear liquids include water, tea, black coffee, clear broth, apple juice, Gatorade, soda, and Jell-O. Do not add milk products to beverages. **Stop clear liquids 4 hours before your procedure.**
- ☐ Do not have gum or hard candy within 4 hours of your procedure.
- ☐ Take all of your usual medications including medications for high blood pressure with small sips of water.

After Your Procedure

- ☐ You will be monitored in the Endoscopy Unit Recovery Area for approximately 1 hour.
- ☐ Please bring personal items in case you are admitted to the hospital after the procedure.
- ☐ You will receive diet and medication instructions.
- ☐ You may return to work the day after the procedure.

Please note, we are an Endoscopy Unit facilitating both outpatient and inpatient needs.
Due to the nature of the complex procedures we perform, unavoidable delays may occur.
Please plan accordingly. Every effort is made to start your procedure on time.
We appreciate your patience and flexibility!

Directions from Parking to Endoscopy Unit

We are located on the 4th Floor of the Blake Building
55 Fruit Street, Boston, MA 02114

From the Fruit Street Garage or Parkman Street Garage:

1. After parking, enter through the MGH main entrance
2. Take the E elevator to the 4th floor of the Blake Building
3. Once you exit the elevator, looks for the glass door labeled MGH GI Associates

For driving directions and more information, please visit the Parking and Visitor Information website
www.massgeneral.org/visit
If you are using GPS, please be sure to verify the zip code

This document was reviewed by the staff of the Blum Center for plain language.

MASSACHUSETTS GENERAL HOSPITAL

CONSENT FOR PROCEDURE

Patient Identification Area
PATIENT MUST BE IDENTIFIED BY
NAME AND MEDICAL RECORD NUMBER

I hereby authorize _____ to perform the following procedure(s)

Procedure UPPER GI ENDOSCOPIC ULTRASOUND (UPPER EUS)

Site: Massachusetts General Hospital If laterality applies: ☐ Right ☐ Left ☐ Both Sides ☒ NA

I have been informed of 1) the potential risks and benefits of the procedure(s); and 2) the risks and benefits of the alternatives, including the consequences of not having the procedure(s).

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the proposed treatment(s) or procedure(s).

Further I am aware that there are possible risks, such as loss of blood, infection or pain that may accompany any surgical, diagnostic or therapeutic procedure. The following additional risks were explained to me:

Endoscopic Ultrasound is an important test for the diagnosis, staging, and treatment of GI disorders and malignancies. The exam will be performed with an endoscope that will examine the upper GI tract. If an abnormality is seen, a needle aspiration may be performed. Needle aspiration may cause bleeding, pain, infection, or pancreatitis. Perforation and bleeding are very rare complications but may be serious and require hospitalization, blood transfusion, or surgery.

There is potential for bruising or soreness in the mouth. In rare instances, teeth may be dislodged or damaged.

Additional Procedures:
- Celiac Neurolysis
- Pseudocyst Drainage
- Cyst Injection

If procedural sedation will be used during this procedure, I understand that this sedation has risks. My physician has discussed the use of procedural sedation. The risks include but are not limited to slower breathing and low blood pressure that may require treatment.

I understand that a potential risk or complication of the procedure is the loss of blood. I understand that I may require blood products during the procedure or in the post-procedure period. If I refuse blood products, I will complete a separate release for blood-free treatment form.

I understand that one or more healthcare industry professionals (technical representatives for medical equipment and device companies) or observers may be present during this procedure for advisory or observational purposes only.

The hospital may photograph, videotape, or record my procedure/surgery for educational, research, quality and other healthcare operations purposes. Any information used for these purposes will not identify me.

I understand that blood or other samples removed during this procedure may later be disposed of by Massachusetts General Hospital. These materials also may be used by Massachusetts General Hospital, its partners, or affiliates for research, education and other activities that support Massachusetts General Hospital's mission.

A team of medical professionals will work together to perform my procedure/surgery. The role and involvement of the senior attending in my procedure has been discussed with me, including that he/she may join the procedure after the opening of the surgical site or may leave during the closing of the surgical site, and may need to step away during non-critical portions of the procedure. The roles of additional practitioners involved in the procedure, indicated below, have also been explained to me. I understand that other medical professionals may be involved in the procedure who are not listed below. The name of those practitioners will be shared with me after the procedure.

Role of Practitioner (check all that apply)		Name of Practitioner if known
	Fellow.	
	Resident. Specify Year:	
	Physician Assistant	
	Advanced Practice Nurse	
	Other, please specify:	
	Other, please specify:	

I have had a chance to ask questions about the risks, benefits, side effects, likelihood of achieving the goals of this procedure, and other approaches. All my questions were answered to my satisfaction and I give permission to have the procedure.

			AM PM
Patient/Surrogate Decision Maker Signature	Printed Name if not Patient	Date	Time
Practitioner Obtaining Consent Signature	Printed Name	Date	AM PM Time

Attending Physician/Primary Practitioner Attestation (not required if individual obtained original consent)
I attest that I discussed all relevant aspects of this procedure/surgery, including the indications, risks, and benefits, as compared with alternative approaches with the patient or surrogate decision maker, answered their questions, and provided information regarding other medical professionals who will be present during the surgery.

			AM PM
Attending Signature	Printed Name	Date	Time

If interpreter was used please complete name or number of interpreter: _____

Telephone Consent
Date: _____ Time: _____ AM PM
Reason for Telephone Consent:_____
Surrogate Decision Maker Name:_____
Consent Received by:_____
Consent Witnessed by:_____