



**CONSENT FORM
FOR
PERCUTANEOUS ENDOSCOPIC
GASTROSTOMY**

Med Rec. No.....

Surname:.....

Forename:

DOB:.....

AFFIX LABEL HERE

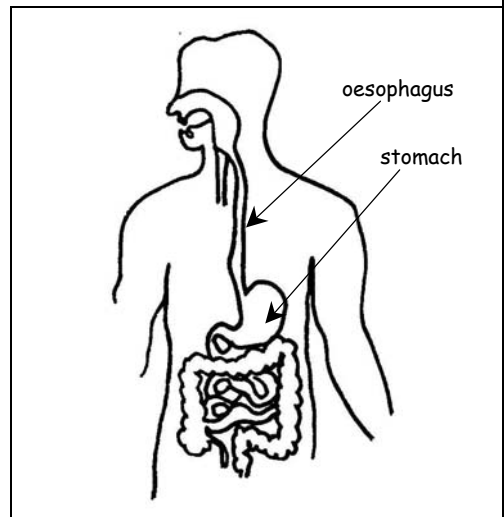
PROPOSED TREATMENT

The doctor has explained that I, (*name of patient*) have the following conditionand that a percutaneous endoscopic gastrostomy is proposed:

This means placing a special feeding device (PEG) or feeding tube through the abdominal wall into the stomach. The mushroom shape of the device holds it in place.

Under sedation and a local anaesthetic, a flexible instrument (endoscope) is passed through the mouth and oesophagus, into the stomach. Air is blown into the stomach to open it up and a hollow needle is passed through the abdominal wall and into the stomach. A long guiding wire is passed through the needle and a snare, that has been passed down a special channel in the endoscope, catches the string.

The snare is withdrawn together with the endoscope, bringing the guide wire out through the mouth. The PEG tube is attached to the end of the guide wire, and this is then guided into place down the oesophagus by pulling the guide wire back through the needle. At the end of the procedure, the mushroom cap of the PEG tube sits snugly against the stomach lining and the stalk of the mushroom comes out through the abdominal wall. The position of the PEG device is checked using the endoscope and the length of the feeding tube cut to size. A nozzle is fitted to the end of the gastrostomy tube to enable liquid food to be put into the stomach.



Antibiotics are usually given during the operation to reduce the chance of infection.

RISKS

These are the commoner risks. There may be other unusual risks that have not been listed here. Please ask your doctor if you have any general or specific concerns.

I may have side effects from any of the drugs used. The commoner side effects include drowsiness, light-headedness and nausea.

I understand the procedure has the following **specific risks and limitations**:

- The sedation used may cause some slowing or lightening of my breathing. In a few cases, where sedation is especially deep, there is a risk of aspirating fluid into the lungs.
- PEG insertion does not suit everyone and a suitable site may not be available.
- Infection may occur at the operation site, despite antibiotics given during the procedure.
- There may be some bleeding that usually settles by itself, but which may require intervention.
- The needle may damage other organs when it is inserted, as there is no surgical wound.
- I may have more gastro-oesophageal reflux after the operation. There is a risk of spill over into the lungs, causing pneumonia, so I should only be fed sitting up or lying on my right side.
- I am likely to find the PEG painful for 24 hours or so, but pain medicine will be available.
- The tube may rarely dislodge or become blocked, and may need to be replaced.
- There may be some tissue reaction (granulation tissue) at the tube site. This can be treated simply.
- When the tube is removed, the wound will heal, but there may be a short period when there is a discharge.
- I will have a small scar on the abdominal wall after removal of the device.

RISKS CONTINUED OVERLEAF →

HOSPITAL

**CONSENT FORM
FOR**

**PERCUTANEOUS ENDOSCOPIC
GASTROSTOMY (STAGE 1)**

Med Rec. No.....

Surname:.....

Forename:

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RISKS CONTINUED:

I understand some of the above risks are more likely if I smoke, am overweight or have heart disease, high blood pressure or diabetes..

INDIVIDUAL RISKS

I understand the following are possible significant **risks and complications specific to my personal circumstances**, that I have considered in deciding I will have this operation:

DECLARATION BY PATIENT

- I acknowledge the doctor has informed me about the procedure, alternative treatments and answered my specific queries and concerns about this matter.
- I acknowledge that I have discussed with the doctor any significant risks and complications **specific to my personal circumstances** that I have considered in deciding to have this operation.
- I agree to **any other additional procedures** considered necessary in the judgement of my doctor during this operation.
- I agree to the disposal by the hospital authorities of any tissues that may be removed during the procedure. I understand that some tissues or samples may be kept as part of my hospital records.
- I understand that a doctor other than a gastroenterologist may perform the procedure.
- I have received a copy of this form to take home with me.
- If any staff member is injured or exposed to my blood or other body fluid then I give my consent to a sample of my blood being collected for the purpose of testing for infectious diseases, such as Hepatitis B, C and HIV. I understand that no testing of the blood sample will be carried out without prior discussion and my explicit consent.

Signature of patient

Date

If the patient is an adult and unable to give consent, a proxy form must be completed and attached

DECLARATION BY DOCTOR

- I declare that I have explained the nature of the patient's condition, the procedure to be performed, and discussed the risks that particularly concern the patient.
- I have given the patient an opportunity to ask questions and I have answered these.

Doctor's signature

Doctor's name

Date

(please print)

INTERPRETER'S DECLARATION

I confirm I have accurately interpreted the contents of this form and the related conversations between the patient and the doctor

Interpreter's
Signature

Date

Interpreter's name

(Please print)