LIFESPAN THERAPY

Speech • Language • Cognition • Swallowing

Consent for Endoscopy Procedure (Videostroboscopy)

I, _____, authorize the Speech Pathologist at Lifespan Therapy to perform a rigid and/or flexible endoscopy for analysis of throat, voice and/or swallowing abnormalities. I understand that this is a diagnostic procedure which will assist Speech pathology in formulating specific therapeutic modalities.

Risks: This authorization is given with the understanding that any procedure involves some risks.

Possible adverse reactions which have been considered prior to this patient's selection include:

1. Discomfort (most frequent)
2. Epistaxis (nose bleeding) anterior or posterior (0.3%-1.1%)
3. Pre, intra, post-swallowing inhalation (penetration of the food in the airway) producing the possible risk of infection in the airways especially if the coughing reflex is not efficacious
4. Vasovagal episodes (brief episodes of fainting) (0.06%)
5. Laryngospasm (closure of the vocal cords with acute breathing difficulty) (0.03%)
6. Laceration of the mucosa (an exceptionally rare complication)

I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not result in a cure of the condition.

I have read and fully understand this consent form and understand I should not sign this form if items, including all 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 and hazards of the proposed procedure, ask before signing this consent form.

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.

Patient/Responsible Party: _____ Date: _____

Therapist's Signature: _____ Date:_____

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