

**INFORMED CONSENT FOR ESOPHAGEAL DILATION**

**Explanation of Procedure**

The passing of progressively larger, soft, flexible tubes (dilators) through the mouth and down the esophagus (food or swallowing tube), stretching any narrowed portion or stricture. This opens the esophagus to a more normal size and allows food and liquids to pass to the stomach without difficulty. You may be given medication in the vein to make you sleepy (moderate sedation), however, some discomfort may be experienced during the procedure.

**Principal Risk and Complications of Esophageal Dilation**

Dilation is generally a low risk procedure. However, all of the complications below are possible and your physician will discuss their frequency with you. You must ask your physician if you have any unanswered questions about your procedure.

1. **PERFORATION:** Passage of the dilator may result in an injury to the esophagus with possible leakage of stomach contents into the body cavity. If this occurs, surgery to close the leak may be required.
2. **BLEEDING:** Bleeding may also be a complication. Management may consist only of careful observation, but may require blood transfusions or possibly a surgical operation.
3. **MEDICATION REACTIONS:** You may have an allergic reaction to the medication or you may experience increased sedation. If this occurs, medication can be given to reverse the effects of the medications. Medications used for sedation may irritate the vein. This causes a red, painful swelling of the vein and surrounding tissue. The area could become infected. Discomfort in the area may persist for several weeks to several months.
4. **OTHER:** This includes complications from other diseases you may already have. You must inform your physician of all your allergies and medical problems.

**Alternatives of Esophageal Dilation**

Surgery to the esophagus may possibly be an alternative in some cases.

I certify that I understand the information regarding ESOPHAGEAL DILATION. I have been fully informed of the risks and possible complication of my procedure. I hereby authorize and permit «USName» and whomever he may designate as his/her assistant to perform the esophageal dilation. If any unforeseen condition arises during the procedure calling for additional procedures or treatments, I authorize him/her to do whatever he deems advisable. If surgery is required, I realize I must be transferred to another facility for this. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me concerning the result of this esophageal dilation.

Date	Time	Signed by patient or legally authorized person	
Date	Time	«USName»	
«PName»		«PDOB»	«USName»
«PNumber»			