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Endoscopic Mucosal Resection (EMR) Consent Form

- **Full Name:** _____
- **Date of Birth:** _____
- **Medical Record Number:** _____

The purpose of the EMR procedure is to remove abnormal or precancerous lesions from the lining of the digestive tract using an endoscope. EMR involves the use of an endoscope (a flexible tube with a camera) to visualize and remove abnormal tissue from the lining of the digestive tract. This is generally done by injecting a solution under the lesion to lift it from the deeper layers, then resecting it using a snare.

The benefits of the procedure are that it is a minimally invasive alternative to surgery, removes precancerous or cancerous lesions and allows for histological examination of removed tissue. EMR can be done on an outpatient basis and avoids the time, cost and risk involved with surgery.

The potential complications include bleeding, perforation (a hole in the wall of the digestive tract), infection, pain or discomfort, incomplete resection of lesions, oesophageal narrowing which may require dilatation (in the case of oesophageal EMR), reaction to sedation/anaesthesia or aspiration pneumonia. If these complications occur then hospitalisation, repeat procedures, blood products and/or surgery may be required. I understand that these may carry additional risks which will be discussed with me at that time.

The alternatives to EMR may include, surgical resection, endoscopic submucosal dissection (ESD) or surveillance with repeat endoscopy and biopsy.

Pre-Procedure: bowel preparation and fasting instructions will be provided along with instructions about how to manage any blood thinners or medications for diabetes and weight loss around the time of the procedure.

Post-Procedure: as sedation will be used you should not drive, operate machinery or make important decisions until the following day. You must be discharged into the care of a responsible adult following the procedure.

Patient Acknowledgment:

- I have had the opportunity to ask questions about the procedure, risks, benefits, alternatives, and preparation. I understand the information provided and voluntarily consent to proceed with the EMR. I consent to any necessary treatment or interventions that may arise during the procedure.

Signatures:

Patient Signature: _____ **Date:** _____

Doctor Signature :_____**Date:** _____