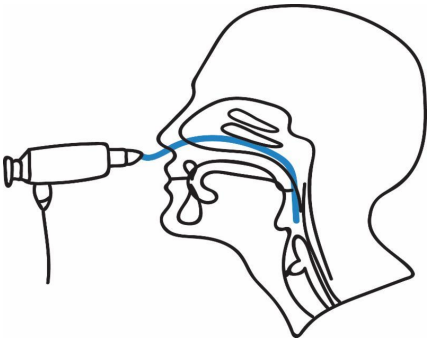
SDX-FEES.COM

PATIENT CONSENT FORM

Background

The functional Fiberoptic Endoscopic Evaluation of Swallowing (FEES) is a procedure which utilizes modern technology to evaluate and manage swallowing difficulties. The procedure uses a fiberoptic laryngoscope which is passed transnasally (slides in along the floor of the nose) to the hypopharynx (the back of the throat). At this point, the larynx and the surrounding structures can be viewed. The scope hangs quite high in the throat, and does not pass between the vocal folds. Colored foods and liquid are given to the patient, and the swallow is viewed. *Please retain this form for your facility records.*



Uncommon, and rare but possible adverse reactions as reported in the literature, which have been considered prior to this procedure:

1. nosebleed (likelihood of 1/300 patients);
2. fainting (vasovagal response, likelihood of 4/6,000 patients);
3. an abrupt tightening of the vocal folds if the endoscope passes between the vocal folds (laryngospasm, likelihood of 2/6,000 patients).

REFERENCES:

Dziewas, R., auf dem Brinke, M., Birkmann, U. et al. Safety and clinical impact of FEES – results of the FEES-registry. Neurol. Res. Pract. 1, 16 (2019). https://doi.org/10.1186/s42466-019-0021-5.

Nacci A, Ursino F, La Vela R, Matteucci F, Mallardi V, Fattori B. Fiberoptic endoscopic evaluation of swallowing (FEES): proposal for informed consent. Acta Otorhinolaryngol Ital. 2008 Aug;28(4):206-11. PMID: 18939710; PMCID: PMC2644994.

Please Sign Below:

I, _____, understand that a FEES test has been ordered for _____. The procedure has been explained to me, including possible adverse reactions. I give my consent for this procedure and for the recording of this procedure. I understand that the recording and its images may be used for educational, research, and teaching or publication purposes, and if so utilized will be de-identified. I give my consent to FACILITY NAME:_____ to release any medical information necessary to process claims for this service, and I authorize my insurance company and/or Medicare to make payments on my behalf to the named facility.

CONSENT GIVEN: (Choose one, either Verbal via Phone or Written in person)

☐ **Verbal via Phone Contact**

_____ 1st Witness _____ Date _____ Time

_____ 2nd Witness _____ Date _____ Time

. ☐ **Written in person**

_____ Patient or Patient Representative _____ Date

_____ Witness _____ Date

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