Consent form

Patient agreement to endoscopic investigation or treatment

Name of procedure(s) (include a brief explanation if the medical term is not clear)

Oesophago-gastro-duodenoscopy/endoscopy/gastroscopy

Inspection of the upper gastrointestinal tract with a flexible endoscope (with or without biopsy and photography). Biopsy specimens will be retained.

Statement of patient

You have the right to change your mind at any time, including after you have signed this form

I have read and understood the information in the attached booklet including the benefits and any risks.

I agree to the procedure described in this booklet and on the form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

Where a trainee performs this examination, this will be undertaken under supervision by a fully qualified practitioner

I would like to have: local anaesthetic throat spray □ or sedation □ please tick box

Signed                      Date

Name (print in capitals)

If you would like to ask further questions please do not sign the form now. Bring it with you and you can sign it after you have talked to the healthcare professional

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure).

I have confirmed that the patient/parent understands what the procedure involves including the benefits and any risks.

I have confirmed that the patient/parent has no further questions and wishes the procedure to go ahead.

Signed                      Date

Name (print in capitals)     Job title

If your patient requires further information please complete page 3
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Signed Date

Name (print in capitals) Job title
Statement of health professional (to be filled in by a health professional with appropriate knowledge of proposed procedure, as specified in the consent policy)

In response to a request for further information I have explained the procedure to the patient. In particular, I have explained:

The intended benefits
1. To diagnose and treat a possible cause of your symptoms
2. To review the findings of any previous endoscopy

Serious or frequently occurring risks
Endoscopy risks: Perforation, bleeding, damage to teeth

Sedation or throat spray risks: Adverse reaction to any of these agents

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment), any extra procedures which may become necessary and any particular concerns of those involved.

Signed __________________________ Date ______________

Name (print in capitals) __________________________ Job title ______________

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient/parent to the best of my ability and in a way in which I believe she/he/they can understand.

Signed __________________________ Date ______________

Name (print in capitals) __________________________