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 with or without oesophageal dilatation

Inspection of the upper gastrointestinal tract with a flexible endoscope (with or without biopsy and photography) and stretching of the gullet (oesophagus) to enlarge the diameter to enable the passage of food.

Biopsy samples 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: sedation [ ] no sedation, local anaesthetic throat spray [ ]

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
Patient details

Consent form

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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: sedation [ ] no sedation, local anaesthetic throat spray [ ] (necessary if dilation required) 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.

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Signed _______________________________ Date _______________________________

Name (print in capitals) _______________________________ Job title _______________________________

If your patient requires further information please complete page 3
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

Risks associated with your treatment
I have discussed the serious risks associated with the treatment of your oesophageal disease which are set out on pages 5 and 6 of the attached booklet

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) ____________