CONSENT FORM

Name of procedure: GASTROSCOPY (Oesophago-gastro-duodenoscopy)
Inspection of the upper gastrointestinal tract (oesophagus, stomach, duodenum) with a flexible endoscope (with or without biopsy, photograph/video recordings, removal of polyps, injection treatment). Biopsy samples will be retained.

ADDRESSOGRAPH

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.

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

Significant, unavoidable or frequently occurring risks:
1. Endoscopy risks – perforation, bleeding, damage to teeth or bridgework
2. Adverse reaction to sedation or throat spray
3. Incomplete procedure or missed lesions

I agree to the procedure described in the Gastroscopy booklet and on this Consent 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 the supervision of a fully qualified practitioner.

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I would like to have: **Local anaesthetic throat spray** ☐ **Sedation** ☐ **(please tick)**

If there is anything you do not understand or that you wish to discuss further you do not have to sign the Consent Form in advance. Bring it with you and you can sign it after you have talked to the healthcare professional.

Patient signature: **Date:**

Name (print in CAPITALS):

Confirmation of consent (to be completed by a healthcare professional when the patient attends for the procedure):

I have confirmed that the patient understands what the procedure is likely to involve, the benefits and risks of this and any available alternative treatments (including no treatment) and any extra procedures which may become necessary.
I confirm that the patient has no further questions and wishes the procedure to go ahead.

Healthcare professional signature: **Date:**

Name (print in CAPITALS): **Job title:**

Statement of interpreter: (where appropriate)
I have interpreted the information above to the patient to the best of my ability and in a way in which I believe they can understand.

Interpreter signature: **Date:**

Name (print in CAPITALS):