Endoscopy and Colonoscopy Consent

Informed consent. The gastroenterologist fills the treatment details and explains them; the patient or their representative signs.

Clinic and clinician

HOSPITAL OR CLINIC

GASTROENTEROLOGIST NAME

REGISTRATION NO. (MEDICAL COUNCIL)

PATIENT ID / UHID

Patient

PATIENT FULL NAME

EMAIL

DATE OF BIRTH

GENDER

PHONE

Proposed treatment

PROCEDURE

PLANNED DATE

SEDATION

BOWEL PREP GIVEN

A flexible tube with a camera is passed through the mouth or back passage to look inside. Small tissue samples (biopsies) may be taken and polyps removed during the same procedure.

Risks

Every treatment carries some risk. The common and the serious ones for this treatment include:

- Bloating and discomfort afterwards
- Bleeding, especially after polyp removal
- A tear (perforation) needing surgery (rare)
- Reaction to sedation; you must not drive for 24 hours
- A small growth may be missed

RISKS SPECIFIC TO THIS PATIENT

Alternatives

- CT scan or barium study
- Stool tests
- No investigation

Your health

Do you take blood thinners or diabetes medicine?

○ No ○ Yes

Have you followed the fasting / bowel preparation instructions?

○ No ○ Yes

ALLERGIES, CURRENT MEDICINES, OR DETAILS OF ANY "YES"

☐ I agree that polyps may be removed and biopsies taken during the procedure.

Consent

EXPLAINED TO ME IN

SIGNED BY

REPRESENTATIVE NAME (IF NOT PATIENT)

RELATIONSHIP

- The gastroenterologist has explained the treatment, its purpose, risks and alternatives in a language I understand, and answered my questions.
- I understand no result can be guaranteed.
- This consent covers only the treatment described. If an unexpected problem arises during it that puts life or health at immediate risk, the team may do what is needed to deal with it and will explain afterwards.
- I may withdraw this consent at any time before the treatment starts.

☐ I give my consent to the treatment described above.

Patient

SIGNATURE

PRINTED NAME

DATE

Gastroenterologist

SIGNATURE

PRINTED NAME

DATE