

Consent for GASTROSCOPY

IMPORTANT

Please follow the steps below, BEFORE you attend your appointment:

Step 1. Read the patient information leaflet provided which explains your gastroscopy, what to expect when you come to hospital and how to prepare for the test.

Step 2. Read this consent form which includes information about the procedure.

Step 3. Once you have read the consent form and patient information leaflet, if you have further questions, please contact the endoscopy unit between 8.30am – 3.00pm, Monday to Friday on 020 8725 1913.

Step 4. If you are in agreement with, and understand the procedure(s) you are attending for, please print your name and sign and date the box in the relevant section on page 3.

Step 5. Please bring this signed document with you to your appointment.

Consent for Gastroscopy/OGD

(Flexible camera examination of upper Gastrointestinal tract)

(Please complete or affix label)

Surname:.....

Forename:.....

Date of birth:..... MRN No:.....

Male ☐ Female ☐ Other ☐

Statement of patient’s understanding of gastroscopy/OGD:

I understand the intended benefit of the gastroscopy is to aid diagnosis and/or facilitate treatment. This may involve taking biopsies.

I have read and understood that:

- The time taken to perform the procedure is variable, but that most gastroscopies are completed within 10 minutes.
- I will be asked to drink a 50ml solution of Infacol mixed with water before the procedure to help reduce the bubbles in my stomach. This helps facilitate clear views during the procedure.
- An anaesthetic spray will be applied to the back of my throat to reduce my gag reflex and allow for easier passage of the endoscope. The effects of the spray normally last up to 30 minutes..
- I have a choice of also having a sedative and/or pain relief administered intravenously for the procedure. This is very safe but may affect my breathing, heart rate and blood pressure. A nurse will be with me in the room throughout the procedure, and in the recovery area afterwards, to monitor my wellbeing and vital signs. I will have made arrangements to be accompanied home after the procedure and I will be in the presence of a responsible adult for at least 12 hours after leaving the endoscopy department. I understand I am not allowed to drive for 24 hours following administration of sedation.
- The procedure may make me feel bloated, and may leave me with a sore throat but this usually settles within a few hours.
- During diagnostic gastroscopy, there is a small risk of causing a complication:
 - There is a risk of dislodging loose teeth, crowns and bridgework, but this is rare.
 - Overall, the risk of causing any significant bleeding is less than a **1:2000**. Minor bleeding is to be expected from the site of any biopsies taken, and this bleeding usually stops spontaneously. If bleeding does not stop spontaneously it can usually be treated by the endoscopist during the procedure.
 - The risk of causing a perforation (unwanted tear in the upper digestive tract) is **1:3000**.
 - If significant bleeding and/or a perforation cannot be treated by the endoscopist at the time of the procedure, admission to hospital and further intervention, including treatment with antibiotics, radiological embolization (to stop bleeding) or surgery may be required.
- There is a small risk of an abnormality being missed.
- On occasion, it will not be possible to complete the procedure. If this occurs, you may be offered the opportunity to have the procedure repeated on another day, or an alternative investigation may be suggested.

What are the alternatives?

There are some alternatives to gastroscopy, but these are not suitable for all patients. Your clinician will discuss this with you if appropriate.

Statement of agreement to proceed with gastroscopy/OGD:

I understand:

- the information provided to me regarding the gastroscopy, including the reasons for it, the risks and benefits and any alternatives.
- I have the right to change my mind at any time, including after I have signed this form.
- the endoscopist performing the procedure will have appropriate experience, or if performed by a trainee they will be closely supervised by an experienced endoscopist.
- that photography is an integral part of the procedure and will be part of my medical record.
- 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.
- and agree that tissue (biopsies) removed as part of the procedure may be used for diagnosis and audit and stored / disposed of as appropriate and in a manner regulated by appropriate ethical, legal and professional standards.
- additional procedures may become necessary during my procedure to assist diagnosis and treatment or to manage complications. I have listed below any procedures which **I do not wish** to be carried out without further discussion.
Please list:

Please answer the following questions before signing the form below:

I consent to receiving blood products in the event of a medical emergency.

Yes / No

If I answered **No** above, I have an advance directive / living will relating to aspects of my current medical care and an official copy has been provided (including Jehovah’s Witness Statement).

Yes / No

I agree that anonymised endoscopy images and/or videos from my procedure may be used for teaching and training purposes.

Yes / No

Patient signature:.....Date:.....

Name (PRINT):.....

A witness should sign below if the patient is unable to sign but has indicated their consent.

Signed:.....Date:.....

Name (PRINT):.....

Statement of interpreter (where appropriate)

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

Interpreter’s signature:.....Date:.....

Name (PRINT):.....OR phone ref no:

Hospital use only:

Statement of health professional:

- I have confirmed the patient’s choice of:
 - ☐ No medication
 - ☐ Throat spray
 - ☐ Conscious sedation
 - ☐ IV analgesia
 - ☐ Entonox
 - ☐ Other:
- I have confirmed that the patient understands the information provided, has no further questions and wishes to go ahead with the procedure.
- I have confirmed that a procedure specific patient information leaflet has been provided.

Signed: Date:

Name (PRINT): Job title: