LUTON & DUNSTABLE UNIVERSITY HOSPITAL

CLINICAL EXCELLENCE, QUALITY & SAFETY

For staff use only
Surname:
First names:
Date of birth:
Hospital No:
Male/Female
(Use hospital identification label)

Name of Consultant team performing the investigation:

Office no:

Name of proposed procedure:

Endoscopic examination and procedures

Introduction:

- An endoscopic procedure has been requested. The procedure is described in the accompanying leaflet, with the reasons for the test, benefits, risks and alternatives. Before the procedure is to be performed you will need to understand it fully and then sign the consent form. **Please bring this consent form with you** to the Endoscopy Unit. If you wish you can sign it at home or you can sign it in the Endoscopy Unit after you have had the opportunity to discuss it with one of the Endoscopy Nursing or Medical Staff. The form will be signed by a Healthcare Professional in the unit (either one of the Endoscopy Nursing or Medical Staff) after they have discussed the procedure with you.

- If you would like this information in another language please telephone the Endoscopy Booking Office (01582 497273).

- In any endoscopic procedure, sometimes biopsies need to be taken. These biopsies are usually very small pieces of tissue which are taken and put onto slides for microscopic examination. These slides are usually retained for a number of years and any excess tissue is discarded during preparation of the slides. If larger abnormalities such as polyps are removed, more tissue is discarded during preparation but some tissue is still retained in the pathology laboratory. This material is retained for up to 10 years and then disposed of appropriately.

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Name of procedure

……

Statement of patient

Please tick the boxes to indicate that you understand and either agree or disagree to the statements below:

	Yes	**No**
I have read the information leaflet which explains this procedure.	☐	☐
I understand the risks and the benefits associated with this procedure.	☐	☐
I agree to undergo the above procedure named on this form.	☐	☐
I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person may be a registrar or nurse endoscopist who will have appropriate experience and will have appropriate supervision.	☐	☐
I understand that any procedure in addition to those described on the form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.	☐	☐
I agree that any tissue (including blood) removed as part of the procedure or treatment may be used for diagnosis and audit, stored or disposed of as appropriate and in a manner regulated by appropriate ethical, legal and professional standards.	☐	☐
I agree to the use of photography and video recording for the purpose of diagnosis and treatment.	☐	☐
I agree to the use of anonymised photographs or video records for the purpose of training.	☐	☐
I am aware that additional procedures may occasionally be necessary. I am happy for these to be undertaken without further discussion **OR**	☐	☐
I have listed below any procedures which I do not wish to be carried out without further discussion:-		

.....

I have the right to change my mind at any time after i have signed this form and at any time during the procedure. If i indicate that i wish the procedure to be discontinued, it will be. However i understand that this may prevent a diagnosis being made and may affect future treatment.

The procedure may involve:

Local anaesthetic	☐
Sedation	☐
Pain relief injection	☐
Nitrous oxide gas	☐
Deep Sedation	☐

PTO

CONSENT FORM FOR:

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I have been informed and understand that if I am having sedation and/or pain relief I MUST NOT drive, operate machinery, return to work, drink alcohol, be responsible for the care of another person (child/adult), sign any legally binding documents or be left alone without a responsible adult for 24 hours post procedure

Patient's signature: ……..……..…….. Date: ……

Name (PRINT): ……

I would like to retain a copy of this consent form when it has been signed ☐

If the patient is unable to sign but has indicated his/her consent, a witness should sign below.

Witness's signature: ……..……..…. Date: ……

Name (PRINT): ……

Statement of interpreter (if appropriate)

I have interpreted the information to the best of my ability and in a way in which I believe he/she can understand:

Interpreter's signature ……..…… Date: ……

Name (PRINT): …….

ID Number……..

Telephone interpreting system used ☐

TO BE COMPLETED BY A HEALTHCARE PROFESSIONAL
Nurse led consent ☐ **Endoscopist consent (Therapeutic procedure)** ☐

I have discussed what treatment or procedure is to be undertaken, the patient has read the appropriate information and has been given an opportunity to discuss benefits, risks and alternative treatments.

Health professional's signature: ……. Date: ……...

Name (PRINT): …….