

Consent Form (Adults)

Patient agreement to
endoscopic investigation or treatment

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

Responsible health professional/job title

.....

Special requirements (eg other language/other communication method)

Name of proposed procedure or course of treatment

(include brief explanation if medical term not clear)

.....

Statement of health professional

(To be filled in by a health professional with an **appropriate knowledge of the proposed procedure**, as specified in the Hospital's consent policy)

I have explained the procedure to the patient. In particular, I have explained:

• The intended benefits of the procedure including diagnosis and treatment of gastrointestinal disorders

.....

• Any serious or frequently occurring risks from the procedures as detailed in the information leaflet and including those specific to the patient

.....

• Any extra procedures that might become necessary during the procedure

✓ Blood transfusion ✓ Other procedure (please specify) Surgery

.....

I have discussed what the treatment / procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

• The following information leaflet has been provided:

..... Version/Date/Ref:

This procedure will involve:

Local anaesthesia Sedation Other.....

Health professional's signature:Date:

Name (PRINT): Job title: Doctor Nurse

Contact details (if patient wishes to discuss details later)

I have offered the patient information about the procedure but s/he has declined information.

Statement of the interpreter (if appropriate)

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

Interpreter's signature..... Date:

Name (PRINT):.....

Important notes: (tick if applicable)

The patient has withdrawn consent (ask patient to sign/date here)

See also advance directive/living will (eg Jehovah's Witness form)

Copy accepted by patient: yes / no (please circle)

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

Statement of patient

Please read this form carefully. It describes the benefits and risks of the proposed procedure. Do ask if you have any further questions. **You have the right to change your mind at any time before the procedure is undertaken, including after you have signed this form.**

Training doctors and other health professionals is essential to the Health Service and improving quality of care. Your treatment may provide opportunity for such training, where necessary supervised by a senior doctor. You may, however, decline to be involved in formal training without this adversely affecting your care and treatment.

Please read the following:

- I understand** that I will have the opportunity to discuss the details of sedation and/or local anaesthesia before the procedure, unless the urgency of my situation prevents this.
- I understand** that you cannot give me a guarantee that a particular person will perform the procedure. The person undertaking the procedure will, however, have appropriate experience.
- 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 have been told** about additional procedures which may become necessary during my treatment. I have listed below any procedures that **I do not wish, without further discussion, to be carried out.**

.....
I understand that any tissue removed as part of the procedure not required for diagnostics may be anonymised and used for teaching or quality control, and stored or disposed of in a manner regulated by appropriate professional standards.

Please tick boxes to indicate you either agree/disagree to the three points below. Yes No

I agree that tissue not needed for my own diagnosis or treatment can be anonymised and used for **research** which may include genetic research. Any such research will be approved by a research ethics committee and may be conducted within a hospital, university, not for profit organisation or a company laboratory. **If you later wish** to withdraw your consent for the use of your tissue for research, please contact the Patient Advice and Liaison Service at Addenbrooke's Hospital.

I agree to the use of photography for the purpose of diagnosis and treatment.

I agree to anonymised photographs being used for medical teaching.

I confirm that the risks, benefits and alternatives of this procedure have been discussed with me and I have read and understood the above and agree to the procedure (or course of treatment) on this form.

Patient's signature:..... **Date:**

Name (PRINT):

If the patient is unable to sign but has indicated his/her consent, a witness should sign below. Young people may also like a parent to sign here (see guidance notes).

Witness' signature: **Date:**

Name (PRINT):

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signature..... **Date:**

Name (PRINT): **Job Title:**