

# Patient agreement to investigation or treatment

## Endoscopic procedures

**Authors:** Endoscopy Department

**Brief description:**

- Your doctor has requested this examination to help investigate your medical condition to aid diagnosis and management. The examination should cause little discomfort and may be performed under light sedation or local anaesthetic. Please read this form in conjunction with the relevant information leaflet provided.
- Contact details: **Clinic Co-ordinator Tel. 01223 216546**
- Here, we explain some of the aims, benefits, risks and alternatives to this procedure (operation/treatment). We want you to be informed about your choices to help you to be fully involved in making any decisions.
- Please ask about anything you do not fully understand or wish to have explained in more detail.
- If you would like this information in another format or language or would like help completing the form, please ask a member of our staff.

**Please bring this form with you to hospital**

- You will be asked to read this form carefully, and you and your doctor (or other appropriate healthcare professional) will sign it to document your consent.
- All our consent forms are available on the Addenbrooke's website:  
<http://www.addenbrookes.org.uk/consent>
- Guidance for health professionals can be found on the Addenbrooke's intranet site  
<http://nww.addenbrookes.nhs.uk/consent>
- Remember, you can change your mind about having the procedure at any time.

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**For staff use:**

Does the patient have any special requirements? (eg requires an interpreter or other additional communication method)

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.....



# Patient agreement to investigation or treatment

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

Responsible health professional/job title

Special requirements .....  
(eg other language/other communication method)

## Name of proposed procedure or course of treatment

## Statement of health professional

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

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

- The intended benefits of the procedure: Your doctor has requested this examination to help investigate your medical condition to aid diagnosis and management.

- Any serious or frequently occurring risks from the procedures:

- Gastroscopy.** Endoscopic procedures carry a very small risk (1 in 10,000 cases) of haemorrhage or perforation of the gut following which surgery may be necessary. All upper gastrointestinal endoscopies may involve a slight risk to teeth, crowns, or dental bridgework.
- Therapeutic gastroscopy** carries an increased risk of haemorrhage or perforation of the gut (2 or 3 cases per 100).
- Colonoscopy** carries a very small risk (1 in 1000 cases) of perforation of the colon, which would require surgery and possibly a temporary stoma. There is a small risk (1 in 500 cases) of bleeding if polyps are removed: a blood transfusion might then be required.
- Flexible sigmoidoscopy** carries a very small risk of perforation of the colon (1 in 10,000 cases).
- Endoscopic retrograde cholangio pancreatography (ERCP).** ERCP is a surgical procedure that may cause damage to the bile ducts or inflammation of the pancreas. Overall these complications may occur in about 2 or 3 cases per 100. If a sphincterotomy is performed such complications may occur in 6 in 100 cases, if a stent is inserted through an obstruction, complications may occur in up to 7 in 100 cases.
- Bronchoscopy.** After one type of biopsy there is a small risk of haemorrhage or of air leaking from the lung. A chest drain may be required to remove the air.  
Other rare complications from these procedures include aspiration pneumonia and an adverse reaction to the intravenous sedative drugs where sedation is administered.
- Any risks specific to the patient .....

- Any extra procedures that might become necessary during the procedure

Blood product transfusion     Other procedure (please specify) .....

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: .....

This procedure will involve:     Local anaesthesia     Sedation     No sedation

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

Name (PRINT): .....

Job title (please circle)    Consultant    SPR    Nurse Endoscopist    Other .....

Contact details (if patient wishes to discuss details later) Clinic Co-ordinator 01223 216546

## 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)

**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): .....

**Statement of patient**

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy, which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. Do ask if you have any further questions - we are here to help you. **You have the right to change your mind at any time, including after you have signed this form.**

**Please tick boxes to indicate you understand and either agree/disagree to the statements below.**

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| <b>I agree</b> to the procedure (or course of treatment) described on this form.  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>I understand</b> that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>I agree</b> 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. | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>I agree</b> that tissue (including blood) not needed for my own diagnosis or treatment can be used for the following purposes that could benefit other patients.   |                          |                          |
| <b>Teaching</b>   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Research which may include genetic research</b>  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>I understand</b> that all research will be approved by a research ethics committee and undertaken in accordance with appropriate ethical, legal and professional standards.  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>I understand</b> that the research may be conducted within a hospital, university, not for profit organisation or a company laboratory.  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>I agree</b> to the use of photography for the purpose of diagnosis and treatment.  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>I agree</b> to anonymised photographs being used for medical teaching.   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>I understand</b> 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.   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>I have been told</b> about additional procedures which may become necessary during my treatment. I have listed below any procedures that <b>I do not wish, without further discussion, to be carried out.</b>  | <input type="checkbox"/> | <input type="checkbox"/> |

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**Patient's own 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's own 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: .....