

Parental agreement to investigation or treatment for a child or young person

Endoscopic procedures

Authors: Endoscopy Department

Brief description:

- The doctor has requested this examination to help investigate your child's 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.

For staff use:

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

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Statement of the interpreter (if appropriate)

I have interpreted the information to the child and his/her parent(s) to the best of my ability, and in a way in which I believe they can understand:

Interpreter's signature Date:

Name (PRINT):

Statement of parent

Please read this form carefully. If your child's 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 |
|---|--------------------------|-----|--------------------------|
| I agree to the procedure (or course of treatment) described on this form and I confirm that I have 'parental responsibility' for this child. | <input type="checkbox"/> | | |
| I understand 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"/> | | |
| 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. | <input type="checkbox"/> | | <input type="checkbox"/> |
| I agree that tissue (including blood) not needed for my child's own diagnosis or treatment can be used for the following purposes that could benefit other patients. | | | |
| Teaching | <input type="checkbox"/> | | <input type="checkbox"/> |
| Research which may include genetic research | <input type="checkbox"/> | | <input type="checkbox"/> |
| I understand 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"/> | | |
| I understand that the research may be conducted within a hospital, university, not for profit organisation or a company laboratory. | <input type="checkbox"/> | | |
| I agree to the use of photography for the purpose of diagnosis and treatment. | <input type="checkbox"/> | | <input type="checkbox"/> |
| I agree to anonymised photographs being used for medical teaching. | <input type="checkbox"/> | | <input type="checkbox"/> |
| I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my child's situation prevents this. (This only applies to patients having general or regional anaesthesia.) | <input type="checkbox"/> | | |
| 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 child's life or to prevent serious harm to my child's health. | <input type="checkbox"/> | | |
| I have been told about additional procedures which may become necessary during my child's treatment. I have listed below any procedures that I do not wish, without further discussion, to be carried out. | <input type="checkbox"/> | | |

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Parent's signature: **Date:**

Name (PRINT): Relationship to child:

Child's agreement to treatment (if child wishes to sign):

I agree to have the treatment I have been told about.

Signature: **Date:**

Name (PRINT):

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

On behalf of the team treating the patient, I have confirmed with the child and his/her parent(s) that they have no further questions and wish the procedure to go ahead.

Signature: Date:

Name (PRINT): Job Title: