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Endoscopic Ultrasound Patient Consent Form

(24Hours Fasting)

Patient Information:

- **Full Name:** _____
- **Date of Birth:** _____

I, the undersigned, consent to undergo an endoscopic ultrasound. This procedure involves the insertion of a special endoscope combined with ultrasound through the mouth to examine the walls and structures of the gastrointestinal tract and nearby organs. The procedure generally takes 20-30 minutes, but I understand that I will be in hospital for about 4 hours, although delays may occur due to unplanned emergencies or unforeseen circumstances.

I understand the benefits of an endoscopic ultrasound include accurate diagnosis of tumours and diseases of the digestive tract including the oesophagus, stomach, duodenum, pancreas, gallbladder and bile ducts, and minimally invasive biopsies can be performed to assist accurate diagnoses and treatment planning, and therapeutic procedures to assist in pain control.

I understand that the risks of an endoscopic ultrasound may include, but are not limited to: Sore throat, bleeding, especially if a biopsy is taken, adverse reactions to sedatives or anaesthesia including aspiration pneumonia. 2 people in every 100 can get an infection from a fine needle biopsy of a cyst, 1 person in every 100 can experience pancreatitis. This usually settles but rarely can cause death. About 1 person in 1000 can accidentally get a tear (perforation) through the wall of the gut. This may require surgery to fix.

I have received and understand the instructions for preparing for an endoscopic ultrasound. I understand that I need to fast on the day of the procedure (at least 24 hours fasting for food and at least 6 hours fasting for clear fluids). I have also received instructions about how to manage any blood thinners or medications for diabetes and weight loss around the time of the procedure.

I understand that sedation will be used for the procedure and that I should not drive, operate machinery or make important decisions until the following day. I understand that I must be discharged into the care of a responsible adult following the procedure.

I understand that I may withdraw this consent at any time or on the commencement of procedure or treatment. Additionally, that certain clinical information may be required as part of statutory/state health department requirements, (ie: cancer registry). I understand that clinical images may be taken as part of my care and stored within my medical record. These images will not be used for any other purpose without my permission.

Patient Acknowledgment:

I understand that my doctor will be available to answer any further questions I may have at the time of the procedure. I understand the information provided and voluntarily consent to proceed with the endoscopic ultrasound. I consent to any necessary treatment or interventions that may arise during the procedure, such as aspiration of fluid, or biopsy of lesions.

In extremely rare circumstances a blood transfusion may be required following an endoscopic procedure. Please specify if you do not wish to have a blood transfusion.

☐ I DO NOT consent to the administration of blood or blood products

Patient Signature: _____ **Date:** _____

Doctor Signature: _____ **Date:** _____