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Gastroscopy +/- Dilatation Patient Consent Form

Patient Information:

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

I, the undersigned, consent to undergo a gastroscopy. This procedure involves the insertion of an endoscope through the mouth and into the oesophagus, stomach, and upper part of the small intestine to examine these areas. The procedure is generally carried out with me lying on my left side. The procedure generally takes 10 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 that the risks of a gastroscopy may include, but are not limited to sore throat, bleeding (0.5%), especially if a biopsy is taken or a polyp is removed, perforation of the upper digestive tract (0.1%), infection, missed lesions, incomplete procedure, adverse reactions to sedation/anaesthesia, aspiration pneumonia (0.5%). If these uncommon risks occur then hospitalisation, repeat procedures, blood products and/or surgery may be required. I understand that these may carry additional risks which will be discussed with me at that time.

I understand the benefits of a gastroscopy include accurate diagnosis of upper digestive tract conditions, ability to perform therapeutic interventions such as stopping bleeding, removing polyps, obtaining biopsies, dilating strictures and placing feeding tubes. I understand that, generally, the benefits of a gastroscopy are significantly higher than the risks.

I have received and understand the instructions for preparing for the gastroscopy. I understand that I need to fast on the day of the procedure (at least 6 hours fasting for food and at least 3 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 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 gastroscopy. I consent to any necessary treatment or interventions that may arise during the procedure, such as removal of polyps and taking biopsies from the examined areas.

Signatures:

Patient Signature: _____ **Date:** _____

Doctor Signature:_____**Date:** _____