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SAFETY AND RISKS FOR UPPER GIT ENDOSCOPY (GASTROSCOPY)

PLEASE READ CAREFULLY

This important information is not meant to frighten you but it is our responsibility to outline the risks. You can then make an informed decision whether or not to proceed. There are, of course, risks in **not** having the procedure e.g. missed diagnoses including cancer.

Gastroscopy is usually safe and simple. Your throat may be uncomfortable for a day or two but other side effects and complications are unusual. On very rare occasions (less than 1 in 10,000 procedures) severe damage to the oesophagus or stomach can occur at the time of the examination. Dental damage and swollen lips can occasionally occur.

Complications of sedation are uncommon and are usually avoided by administering oxygen and monitoring oxygen levels in the blood during the procedure. Rarely, however, particularly in patients with severe cardiac or chest disease, serious sedation related problems can occur. You must notify the anaesthetist if you have had **any chest pain** on the day of the procedure.

Aspiration of secretion into the lungs is a potentially serious complication, sometimes requiring hospital admission.

If you wish to discuss possible complications with Dr Mohsen before the procedure, please inform the staff. Death is a remote possibility with any interventional procedure.

CONSENT FOR UPPER GIT ENDOSCOPY (GASTROSCOPY or OESOPHAGEAL DILATATION)

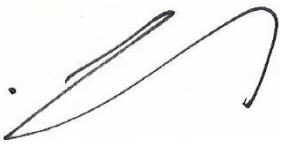
I have read and understood the procedural information on gastroscopy (upper GIT endoscopy) as outlined in the patient information brochure supplied and have read and understand the fees charged for this procedure.

I hereby agree to the performance of the gastroscopy by Dr Mohsen and to the taking of biopsies and performance of oesophageal dilatation or other upper GIT endoscopic procedures deemed to be appropriate by Dr Mohsen at the time of the gastroscopy.

I hereby give Dr Mohsen permission to access or obtain relevant medical information from any other health professional or ancillary service provider. I understand this will assist him in my diagnosis and management.

PATIENTS SIGNATURE…… **WITNESS SIGNATURE……..**

NAME…… **NAME ……**
(Please print) (Please print)
DATE……. **DATE ……**

DOCTORS SIGNATURE : 

PLEASE BRING THIS COMPLETED CONSENT FORM WITH YOU WHEN YOU ATTEND YOUR PROCEDURE