Patient's sticker

Version 12/16

Consent Form For

Gastrointestinal Endoscopy

Endoscope is a flexible tube containing optic fibers and a video camera, through which display is possible, and channels through which instruments can be passed for the purpose of taking biopsies, polypectomy, burning bleed spots, varicose veins treatment and removal of foreign bodies.
The length of an endoscope ranges from 1.20 - 1.80 meters, with a diameter of about 1.0 inches and it can be used to examine the upper and lower digestive system. Before the examination the patient usually consumes anesthetics and/or tranquilizers and/or a local anesthetics to reduce the sense of discomfort during the examination.
When this refers to an examination of the upper digestive tract (esophagoscopy, gastroscopy), the endoscope is inserted through the mouth. When this refers to an examination of the lower digestive tract (sigmoidoscopy, colonoscopy), the endoscope is inserted through the rectum. Later further instruments are inserted through it as per the required operations. Test duration usually ranges between 15 minutes and an hour. During or after the examination a feeling of discomfort and abdominal bloating might appear. The accuracy\diagnostic ability of this examination depends on the quality of the preparation for the testing and the intestinal structure, and it is known that there are lesions that are not diagnosed even after an endoscopic examination.

Subject name:

Last Name First name ID. Father's Name

Patient's sticker

I hereby declare and confirm that I received a detailed oral explanation from Dr.:

Last Name First name

on the need to conduct **diagnostic and/or treatment** _____ **,** including taking Operation name
biopsies, polypectomy, burning bleeding points or areas, varicose veins treatment and removal of foreign body, another treatment _____ (hereinafter: the "Primary treatment").

I received an explanation concerning the availability of diagnostic and/or other treatment alternatives, their advantages, disadvantages, their side effects and their complications.
I received an explanation concerning the side effects of the primary treatment including pain, discomfort in the throat (in endoscopy of the upper gastrointestinal tract), and a feeling of abdominal bloating.
Also, I have been explained the possible risks and complications including: Bleeding or rapture/perforation of the intestinal wall or other part of the gastrointestinal tract. These complications are uncommon, but they can necessitate, in some cases, hospitalization and further treatments and even surgical repair. Examination of the upper digestive tract can cause damage to teeth due to the insertion of the endoscope through the mouth.
I hereby declare and confirm that I was explained and I understand that it is possible that during or after the primary treatment, as a result of perforation or significant bleeding it could be found that there is a need to take other or additional actions, including surgical procedures, to save lives, prevent physical harm and I also consent to the performance of such different or additional procedures, including surgical operations which in the opinion of the hospital's doctors will be essential or necessary as stated above.
I hereby consent to include provision of anesthetics and/or blurring drugs and/or local anesthesia drugs, after it was explained to me that the use of these drugs can cause, rarely, respiratory disturbances and heart disorders, especially in heart patients and people with respiratory system illnesses, and that there is a possible risk of an allergic reaction of varying degrees to the anesthetic substance.
I know that if the medical center has a university branch, student may take part in the course of the primary treatment, under full supervision.

I know and agree that the primary treatment and all the primary procedures will be performed by whoever is assigned to conduct them according to the procedures and instructions of the Medical Center, and that I have not been promised that they will be done, neither in whole nor in part, by a certain specific person, provided they are conducted with the acceptable responsibility and subject to the law.

Patient's sticker

I hereby declare and confirm that I was presented with a detailed explanation regarding the treatment, I understood it and was given answers to my questions to my full satisfaction.

Date	Time	Patient/Subject signature

Guardian's name (relatedness to the patient)

Guardian's signature (in the case of an incompetent minor or mentally ill)

Patient's sticker

I confirm that I orally explained to the **patient/guardian/patient's translator** all the above in the required detailing, and that he/she signed a consent before me after I was convinced that he/she fully understood my explanations.

Physician's name (stamp)	Physician's signature	Date and time

Translator's name	His relatedness to the patient