מרכז רפואי ע"ש ברוך פדה, פוריה
The BARUCH PADEH Medical Center, PORIYA

מס' זהות:	
שם משפחה:	שם פרטי:
שם האב:	תאריך לידה:
כתובת:	
טלפון:	**מדבקת פרטי מטופל**

טופס הסכמה: אנדוסקופיה של מערכת העיכול

CONSENT FORM: GASTROINTESTINAL ENDOSCOPY

An endoscope is a flexible tube that contains optic fibers through which one can see, and channels through which instruments can be passed for the taking of biopsies, excision of polyps, cauterization of bleeding points, treatment of varices and removal of a foreign body.
The length of the endoscope varies from 1.2 to 1.8 meters, its diameter is 1 cm, and through it is possible to examine the upper and lower digestive tract. Usually, before the examination, the patient receives a sedative medication and/or local anesthesia in order to reduce the discomfort of the examination.
The operation is carried out with the patient lying on his left side. For examination of the upper digestive tract (esophagoscopy, gastroscopy), the endoscope is introduced through the mouth. For examination of the lower digestive tract (sigmoidoscopy, colonoscopy), the endoscope is inserted through the anus. Afterwards instruments are inserted through it as required for the necessary procedure. The procedure lasts, usually, from 15 minutes to an hour. During the examination there is a feeling of discomfort and bloating of the abdomen.

Name of Patient: _____ _____ _____ _____
Last Name First Name Father's Name ID No.

I hereby declare and confirm that I received a detailed verbal explanation from:
Dr. _____ _____
Last Name First Name
regarding the need for a diagnostic and/or therapeutic_____ including the taking of a
Name of procedure

biopsy, excision of polyps, cautery of bleeding points, treatment of varices and removal of a foreign body*.

Indicate other procedure_____(hereafter: the primary procedure").

The existence of alternative diagnostic procedures, their advantages, disadvantages, side effects and possible complications have been explained to me

I hereby declare and confirm that I received an explanation concerning the side effects of the primary procedure including: pain, discomfort, and a sensation of bloating of the abdomen.
I have also received an explanation concerning the possible complications of the primary procedure, including: bleeding, or tear of the wall of the digestive tract, which in some cases require surgical repair. During the examination of the upper digestive tract, damage to teeth is liable to occur due to introduction of the instrument through the mouth. The abovementioned complications are not common.
I hereby give my consent to perform the primary operation.
In addition, I hereby declare and confirm that I received explanation and understand the possibility that during the primary procedure, the need to extend or modify it, or perform additional or different procedures, may arise, in order to save life or prevent physical harm, including additional surgical procedures that cannot be fully or definitely predicted at this time, but whose significance has been made clear to me. I, therefore, also give my consent to such an extension, modification or performance of different or additional procedures, including additional surgical procedures, which the institution's physicians deem essential or necessary during the primary procedure or immediately thereafter.
I hereby consent to the administration of sedative medications and local anesthesia after it has been explained to me that the use of sedative medication is rarely liable to cause disturbances of breathing and

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activity of the heart especially in patients with respiratory or heart diseases, and also the possibility of an allergic reaction of varying degree to the anesthetic medication.
I know, confirm and agree that the primary procedure and any other procedure will be performed by whoever is designated to do so, according to the institutional procedures and directives, and that there is no guarantee that they will be performed, fully or in part, by a certain person, as long as they are performed according to the institution's standard degree of responsibility and according to the law.

Date	Time	Patient's Signature

Name of Guardian (Relationship)	Guardian's Signature (for incompetent, minor or mentally ill patients)

I hereby confirm that I provided the patient / the patient's guardian* with a detailed verbal explanation of all the abovementioned, as required, and that he/she signed the consent form in my presence after I was convinced that he/she fully understood my explanations.

Name of Physician	Physician's Signature	License No.

* Cross out irrelevant option.