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Consent form: Gastrointestinal endoscopy
טופס הסכמה: אנדוסקופיה של מערכת העיכול

Patient label

Name and details of the proposed surgery / procedure (in English and with no abbreviations):

Perfromance of _____ **diagnostic and/or therapeutic**
Procedure name

including biopsy collection, polyp resection,

Cauterization of bleeding spots, treatment of varices and foreign object removal*. Specify other treatment _____(hereinafter: "The main treatment").

The goal of the surgery / the procedure: The endoscope is a flexible tube containing optic fibers enabling visualization, and channels enabling passage of devices for biopsy collection, polyp resection, cauterization of bleeding spots, treatment of varices and foreign object removal. The length of the endoscope ranges between 1.20 to 1.80 meter, its diameter is 1 cm, and it can be used to examine the upper and lower gastrointestinal system. Prior to the test, the patient usually receives sedatives and/or local anesthesia to reduce the sensation of discomfort associated with the test.

The test is performed while the patient is lying on the left side. For examination of the upper gastrointestinal tract (esophagoscopy, gastroscopy), the endoscope is inserted via the mouth. For examination of the lower gastrointestinal tract (sigmoidoscopy, colonoscopy), the endoscope is inserted via the anus.

Subsequently, in accordance with the procedures required, appropriate devices are inserted via the endoscope. The test duration usually ranges between 15 min to 1 hour.

The test is associated with discomfort and abdominal bloating.

Possible risks and complications of the surgery / the procedure: The existence of alternative diagnostic methods, their advantages and disadvantages, their side effects and the possible complications have been explained to me. In addition, it has been explained to me that although the endoscopic test is the best currently available test for detection of polyps and tumors, this test has limitations. The test is capable of detecting most of the large tumors and polyps in the colon, but not all of them.

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I hereby declare and certify that the side effects of main treatment have been explained to me, including: Pain, discomfort and sensation of abdominal bloating. Possible complications have been also explained to me including: Bleeding or rupture of the gastrointestinal wall, which is in most cases require surgical repair.

During examination of the upper gastrointestinal tract, insertion of the device via the mouth may cause damage to the teeth. The aforementioned complications are uncommon.

Special warnings for treatment in cases of special health conditions (if any such conditions exist):

_____

_____

The possible advantages and disadvantages of the surgery / the procedure, the possible alternatives to the surgery / procedure, the possible outcomes if I choose not to undergo it, the possible problems related to recovery from it, and its chances of success, have also been explained to me in detail.

After having received a detailed verbal explanation regarding the need for the performance of the surgery / the procedure, including the desired results, the reasonable risks, and the alternative treatment options possible under the circumstances of this case, including the chances of, and the risks involved in, each one of the possible treatment options offered to me, I hereby provide my consent for the performance of the aforementioned surgery / procedure at the hospital (hereinafter - the main surgery).

It has been explained to me, and I understand, that there is a possibility that during the main surgery it will be discovered that it is necessary to expand its scope, modify it, or perform different or additional procedures, including additional surgical procedures that cannot be pre-anticipated at the present time with certainty or in full; but their implications have been made clear to me. Therefore, I also agree to such expansion(s) or modification(s), or the performance of different or additional procedures, including surgeries which in the opinion of the hospital physicians will be essential or necessary during the main surgery.

I am aware of, and agree to the fact that the surgery and all of the other procedures will be performed by whosoever will be designated to do so, in accordance with hospital procedures and regulations; and that I have received no assurances that they will be performed, all or in part, by any specific person;

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provided that they will be performed with the accepted degree of responsibility at the hospital, in accordance with the law.

Patient response / comments, if any:
_____

_____ _____ _____
Date Time Patient signature

_____ _____
Guardian / medical proxy name Guardian signature
(in the case of a minor or a patient
whose identity is confidential)

I confirm that I have verbally explained all of the information noted above, in the required detail, to the patient / to the patient's guardian / to the patient's medical proxy and that he/she signed the consent form in front of me after I was persuaded that he/she understood my explanations in full.

_____ _____ _____ _____
Physician name and signature License no. Date Time

*Delete the unnecessary