

# Endoscopy Consent Form

**Patient Name:**

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**Date of Birth:**

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**Medical Record Number / ID:**

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**Date of Procedure:**

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**Physician Name:**

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## Procedure

**Type of Endoscopy:**

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**Reason for Procedure:**

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## Risks and Benefits

I have been informed about the nature, purpose, benefits, possible risks, alternatives, and complications of the procedure. I have had the opportunity to ask questions and my questions have been answered to my satisfaction.

## Consent

- I voluntarily consent to the above procedure.
- I understand that unforeseen conditions may necessitate additional procedures.
- I consent to the administration of sedatives, anesthesia, and other medications as needed.

**Patient/Guardian Signature:**

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**Physician/Witness Signature:**

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**Date:**

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**Interpreter (if required):**

Name:

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**Signature:**

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**Date:**

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