

Endoscopy Consent Form

Patient Name:

Date of Birth:

Medical Record Number / ID:

Date of Procedure:

Physician Name:

Procedure

Type of Endoscopy:

Reason for Procedure:

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:

Date:

Physician/Witness Signature:

Date:

Interpreter (if required):
Name:

Signature:

Date:
