APPROVED BY
Order No. 46 of September 20, 2010 passed
by Chief Physician of the Public Institution
Šiauliai Central Multi-Specialty Clinic

INFORMED CONSENT FOR ENDOSCOPY

First name and family name of the patient ……………………………………………
I hereby give my consent to Dr. ………………………………………………
to perform the following procedures:

1. EGDFS (esophagus, stomach and the duodenum)
2. Remove a foreign body from my gastrointestinal tract
3. Take a sample for biopsy
4. Stop bleeding

The details of the procedure or treatment have been explained to me in terms that I understand and I am fully aware of its nature and possible consequences.
I confirm that I understand the following:

1. The following complications are possible after the endoscopy procedure: pain, local inflammatory changes, infection, hematomas, bleeding, perforation of organs, pulmonary embolism, ulcers, necrosis, scarring.
2. The procedure may be opted out of due to anatomical reasons.
3. Surgical intervention may be required in case of certain complications.

I have been duly informed that unforeseen circumstances may occur during the invasive endoscopy procedure, which may lead to additional interventions. I hereby give my consent to Dr. …………………………………………………… to perform all necessary procedures relying on his/her professional competence.

To my best knowledge, I am not allergic to any medications, except (if applicable):
………………………………………………………………………………

I regularly take / do not take blood thinners (please underline the appropriate).

I hereby give my consent:

Signature………………………………………………………………………………
First name and family name of the patient ……………………………………………
Date……………………………………………………………………………………