

Consent Form 3

Patient/parental agreement to investigation or treatment

(Procedures where consciousness not impaired and no tissue samples or photographs are to be taken)

<p>For staff use only:</p> <p>Surname: _____</p> <p>First names: _____</p> <p>Date of birth: _____</p> <p>Hospital no: _____</p> <p>Male/Female: _____</p> <p>(Use hospital identification label)</p>

Responsible health professional/job title

Dr S Middleton/ Consultant physician
 Dr X Ouyang / Clinical Scientist

Special requirements
 (For example, other language/other communication method)

Name of proposed procedure or course of treatment

Stationary oesophageal manometry
 (pressure measurements to examine the movement of the gullet on swallowing).

Ambulatory pH recording.
 (measurement of the amount of acid reflux occurring over a 24 hour period)

Statement of health professional

(To be filled in by a health professional with an **appropriate knowledge of the proposed procedure**, as specified in the Hospital's consent policy)

I have explained the procedure to the patient. In particular, I have explained:

- The intended benefits of the procedure
- Any serious or frequently occurring risks from the procedures including those specific to the patient

I have discussed what the treatment procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

- The following information leaflet has been provided: **Oesophageal Tests (manometry and pH recording)**

Health professional's signature Date:

Name (PRINT): **Dr S Middleton**
Dr X Ouyang

Job title: **Consultant Physician**
Clinical Scientist

I have offered the patient information about the procedure but s/he has declined information.

Statement of the interpreter (if appropriate)

I have interpreted the information to the best of my ability, and in a way in which I believe s/he can understand:

Signed Date: Name (PRINT):

Important notes: (tick if applicable)

- The patient has withdrawn consent (ask patient to sign/date here)
- See also advance directive/living will (eg Jehovah's Witness form)

Statement of patient/person with parental responsibility for patient

I confirm that the risks, benefits and alternatives of this procedure have been discussed with me and I have read and understood the above and agree to the procedure (or course of treatment) on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that the procedure will involve local anaesthesia.

Signature: Date:

Name (PRINT): Relationship to patient:

Witness' signature: Date:

Name (PRINT):

Confirmation of consent (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signature Date:

Name (PRINT): Job Title:

Copy accepted by patient: yes / no (please circle)