

ENDOSCOPY SERVICE BDH-ES/03

As advised by your Specialist rooms	
Date of Admission:	Time of Admission:
	Nothing to drink from:
Complete this form and either: 1. Email to reception@eoc.nz Please also bring the o 2. Drop the form in to us at least 1 week prior to your o 101 Clarence Street, Hamilton	-
Contact Details	
Legal Surname: Legal First Names:	
Date of Birth:	
Postal Address:	
Dietery Requirements: N/A GF	DF VEGAN VEG
Phone 1:	
Email:	
,	Described
GP's Name:	Practice:
Next of Kin	
Name:	Relationship:
Address:	
Contact Person (if different from above)	
Name:	Relationship:
Address:	
Contact Phone Numbers:	
Medical Insurance	
Medical Insurance Company:	Approval Number:
ACC Approval Number:	
Have you been treated in this hospital previously?	Yes No Name previously used:

Endoscopy on Clarence is unable to accept any responsibility for loss or damage to valuables or money belonging to patients.

INFORMATION AND CONSENT FORM

Procedure Information

Upon your arrival you may be requested to wait in the reception area.

- Be advised the time provided to you by your specialist's office serves as your admission time and does not indicate the actual procedure time.
- The examination itself will take place on a bed, where you will remain until you have fully recovered from your procedure.
- You must refrain from driving 12 hours after the procedure if you've received sedation, and 24 hours after the procedure if you've had a general anaesthetic. Please make arrangements for someone to drive you home following the procedure and ensure that a responsible adult stays with you overnight (Please note that driving yourself is not legally permitted).
- Continue taking your regular medications unless you have discussed any changes with your specialist.

About Gastroscopy

Gastroscopy is a diagnostic procedure that examines the lining of the upper gastrointestional tract. This procedure allows specialists to take a closer look at your oesophagus, stomach, and the beginning of your small intestine (duodenum). An endoscope (a thin flexible tube) is passed through the mouth, down your oesophagus and into your stomach and duodenum. Images are viewed by the Specialist. If necessary, biopsies (tissue samples) or polyps can be taken. These specimens are sent to the laboratory for analysis.

However as with most medical procedures, there are potential risks. The risk of a significant complication arising during the procedure is approximately 1 in 5,000. Potential complications include allergic reactions, bleeding, or perforation (a hole in the upper gastrointestinal tract). Despite gastroscopy being a highly accurate diagnostic test, there is also a possibility that some abnormalities may not be detected.

About Colonoscopy

Colonoscopy is a procedure that involves visually inspecting the large intestine (colon) using a narrow, flexible tube known as a colonoscope. This examination allows for a comprehensive view of the entire colon as the colonoscope is gently advanced through it. If necessary, the specialist can collect tissue samples (biopsies) or remove polyps. All samples are sent to a laboratory for analysis.

Typically, a colonoscopy is a safe procedure with infrequent complications. The likelihood of experiencing a significant complication is around 1 in 1,000 procedures. As is the case with most medical procedures, there are some risks. Although rare, these could include:

- · Allergic reaction to medication during your stay.
- Despite colonoscopy being a highly accurate diagnostic test, there is a risk that some abnormalities may not be detected.
- Bleeding and/or perforation (tearing of the bowel wall)

About Haemorrhoid Banding

This procedure is effective for treating internal haemorrhoids, particularly those prone to bleeding or prolapse from the anus. It involves inserting a small scope into the anus and a specialised instrument places rubber bands around the internal haemorrhoids. These rubber bands restrict the blood supply to the haemorrhoids, causing them to detach, along with the bands, within a span of 4 to 7 days.

Complications are very rare. However, in the event of severe bleeding, you must contact your specialist and seek medical attention immediately. On extremely rare occasions (affecting less than 1 person in 100,000), a severe infection can develop.

HEALTH QUESTIONNAIRE TO BE COMPLETED BY THE PATIENT

RELEVANT MEDICAL / SURGICAL HISTORY		
ALLERGIES & REACTIONS	Allergy Sticker	
Have you had a previous gastroscopy/colonoscopy	Yes No Glaucoma	Yes No
Hospitalisation within last six months	Yes No Metalware/Pro	sthesis(joint) Yes No
Asthma/Bronchitis	Yes No Heart problems	s (heart valve) Yes No
Hypertension	Yes No Liver/Kidney dis	sease Yes No
Infectious Diseases (ESBL, MRSA, Hepatitis, TB)	Yes No Blood clotting	oroblems Yes No
Epilepsy	Yes No Possibility of pr	egnancy Yes No
Diabetes	Yes No Other (radiothe	erapy/chemo) Yes No
If YES to any of the above, please provide details		
Have you had any illness/surgery in the past:	Yes No	
If YES, please provide details		
CURRENT MEDICATIONS		
CURRENT MEDICATION (PLEASE LIST)		
Are you on any Blood Thinning Medication Yes	No	
If YES, when did you last take them		
PRE-PROCEDURE NURSING ASSESSMENT - CO	OMPLETE BY ADMITTING I	NURSE
Procedure: Flexi Sig Colonoscopy Gas	other	Time:
RECORDINGS: BP:/Pulse:02 Sats	: BSL: Temp	o:Weight kgs:
Last food: Date: Time:	Last drink: Date:	Time:
Labels and Identification Correct: Yes No D	id you drink all your bowel Pre	ep Yes No
Bowel motions Watery Lumpy Solid B	Enema Required Yes Nur	mber:Result:
TICK APPLICABLE: Own Teeth Partial Plate	Full Dentures Crowns	s Caps Hearing Aid
Private X-Rays Spectacles/Contact Lens	Walking Stick/Aid Consent Sig	gned: Patient Specialis
Patient to be collected by:	Contact Phone i	No:
Nurse Name:	Nurse Signature	:



ENDOSCOPY PROCEDURE RECORD

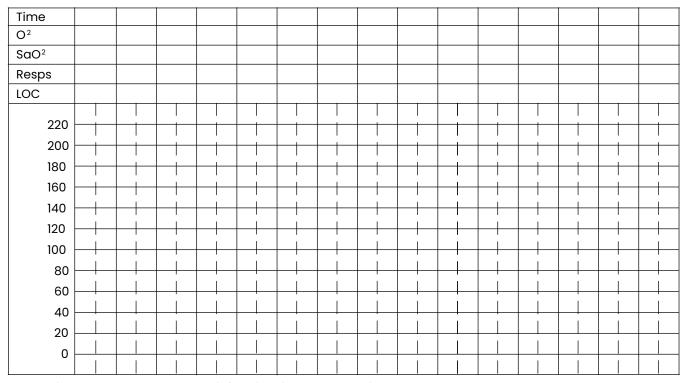
Da	te:		Time In:	Time Out:					
End	doscopist:	Endosco	opy Nurse:	Sedation Nurse:					
Anaesthetist: Anaesthetic Tech:				Professional visitor/s:					
	Gastroscopy	Colonoscopy	Flexi Sigmoidoscopy	Banding Haemorrhoids	Tattooing				
	Other		IV Luer	Yes No					

INTRA-OP

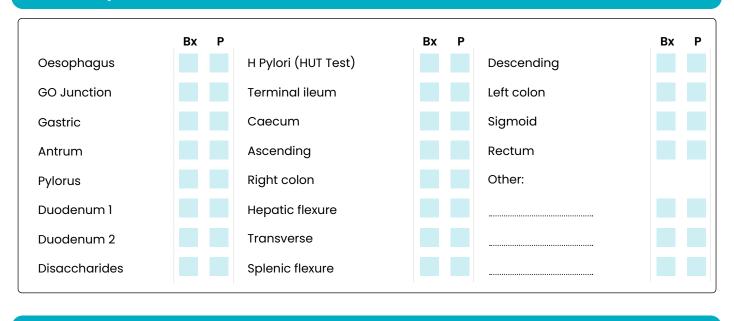
ADMINISTERED MEDICAITON.

Date	Drug		TIME	DOSE	TIME	DOSE	TIME	DOSE	Given by	2nd Nurse	Doctor
	Fentanyl n	mcg/IV									
	Midazolam	mg/IV									
	Hyoscine	mg/IV									
	Lignocaine Spr	ray PO									
IV Fluid IV											
UGI Start Time:			Er	End Time:				Start Tin	ne:	End Time:	

OBSERVATIONS



BIOPSIES/POLYPS



ENDOSCOPY NURSING NOTES

Abdominal Pressure: Yes No Name:	Time Required:
Restart anti-coagulant medication - Start Date:	Sign:

ENDOSCOPY TRACEABILITY STICKERS

ENDOSCOPE NUMBER

TRACEABILITY STICKERS



RECOVERY

Date	Recovery Medication	Dose	Route	Frequency	Doctor's Signature	Nurse's Signature	TIME

RECOVERY RECORD

RECOVERT	(LOOK!														
Arrival Time	Time														
Hrs	O ²														
On Admission	SaO ²														
Unconscious	Resps														
Conscious	200														
Hrs	190													<u> </u>	
A	180														
Anaesthetic General	170 160														
Local	150														
Block	140 130														
Sedation	120				I										
No Sedation	110						l l								
Airway	100 90														
None	80														
Oro	70 60				i										İ
LMA	50		l i	i	i			l i			l i		l i	Li-	
Jaw Support Other	40														
Other	30														
Hudson Mask	LOC														
N/Prongs	Pain Score														
_	Analgesia														
Resps Normal						/		/	/			/	/	$\overline{}$,
Shallow															
Low Rate															
Ventilatory		/ /	/ /	/ ,	/ ,	/ ,	/	/ ,	/ ,	/ ,	/ ,	/ ,	/ ,	/ ,	
Assistance	/ /					/									
DISCHARGE SUMMA	ARY														
Sip Test: Yes	No		IV Lu	ıer:					IV	Fluids	3:				

Discharge Time

Hrs

Nurse's Signature

WARD NOTES

Ward Nursing - I	V Cannula Insertion			
Other:				iize:
Ward Nursing No	ites			
Observations:				mmol/L
Time of Discharge:		Sigr	nature:	
Discharge Check	dist			
	_		IV cannula remove	blicable) d to patient (if applicable)
Follow up phone	call			
Date:	Time:		Nurses Signature:	
	nals Initials – Admin		<u> </u>	
Name (Printed):	REG No.	-	me (Printed):	REG No. Initials



CONSENT TO PROCEDURE AND TREATMENT

THIS SECTION TO BE COMPLETED BY SPECIALIST
Legal Surname:
Legal First Names:
Procedure/Treatment:
Sedation General Local
Risks Discussed: Bleeding 1% perforation 0.1% missed pathology 2%
Specialist Name:
Specialist Signature: Date:
THIS SECTION TO BE COMPLETED BY THE PATIENT (OR PARENT / GUARDIAN)
request and agree for the procedure/treatment described above be performed
on myself/my child (delete one).
I confirm that I have received a satisfactory explanation of the reasons for, risks and likely outcomes of the
procedure/treatment, and the possibility and nature of further related treatment should any complications arise including a return to theatre.
I have been informed of both benefits and risks including rare but serious risks. I understand that if essential, further or
alternative operative/procedural measures may be undertaken during the course of the procedure.
I have had the opportunity to ask questions and may seek more information at any time. I give permission for Endoscopy on Clarence or any other health professional invoved in my care for this admission to
hospital, to access health information about me that is relevant to my current treatment, which may be held by the hospital, other health professionals or other health organisations.
I understand and agree that photographic images may be made and stored confidentiality as part of my health record for this episode of care.
I consent to being given blood or blood products if required Yes No
I understand that should a member of the healthcare team be directly exposed to my blood or other body fluids, I agree to blood samples being taken and tested for blood-borne diseases including Hepatitis and HIV. I understand I will be informed of the results if I request them, and any need for further medical referral.
I wish to have my surgically removed body parts returned to me
(I understand in some circumstances this may not be possible) Yes No
Patient/Parent/Guardian Signature: Date:
CONSENT TO ANAESTHESIA
I agree to anaesthesia/sedation being give to myself (or my child).
I have received a satisfactory explanation of the reasons for, risks and likely outcomes of the anaesthesia and I have had the opportunity to ask questions and may seek more information at any time.
I acknowledge that I should not drive a motor vehicle, operate machinery or potentially dangerous appliances or make important decisions for 24 hours after having a general anaesthesia or sedation.
Patient/Parent/Guardian Signature: Date:
Anaesthetist/Surgeon Signature: Date: