ENDOSCOPY ON CLARENCE

PLEASE AFFIX PATIENT DETAILS LABEL HERE

ENDOSCOPY SERVICE BDH-ES/03

As advised by your Specialist rooms

Date of Admission: ..... **Time of Admission:** .....

Nothing to eat from: ..... Nothing to drink from: .....

Complete this form and either:

1. Email to **reception@eoc.nz** Please also bring the original form with you on the day; or
2. Drop the form in to us **at least 1 week prior** to your admission to our reception, **101 Clarence Street, Hamilton**

Contact Details

Legal Surname: ..... ☐ Miss ☐ Ms ☐ Mrs ☐ Mr ☐ Dr ☐ Mx

Legal First Names: ..... Preferred Name: .....

Date of Birth: ..... Country of Birth: .....

Gender/Pronouns: ..... Are you a permanent NZ resident?: ☐ Yes ☐ No

Ethnicity: .....

Home Address: .....

Postal Address: .....

Dietery Requirements: ☐ N/A ☐ GF ☐ DF ☐ VEGAN ☐ VEG

Phone 1: ..... Phone 2: .....

Email: ..... Email Invoice? ☐ Yes ☐ No

Surgeon or Specialist: .....

GP's Name: ..... Practice: .....

Next of Kin

Name: ..... Relationship: .....

Address: .....

Contact Phone Numbers: .....

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

Allergy Sticker

ALLERGIES & REACTIONS .....

Have you had a previous gastroscopy/colonoscopy	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Hospitalisation within last six months	☐ Yes	☐ No	Metalware/Prosthesis(joint)	☐ Yes	☐ No
Asthma/Bronchitis	☐ Yes	☐ No	Heart problems (heart valve)	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No	Liver/Kidney disease	☐ Yes	☐ No
Infectious Diseases (ESBL, MRSA, Hepatitis, TB)	☐ Yes	☐ No	Blood clotting problems	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Possibility of pregnancy	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Other (radiotherapy/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

(Please tick) ☐ Warfarin ☐ Aspirin ☐ Dabigatran (Pradaxa) ☐ Other .....

If YES, when did you last take them ..... INR Result (if applicable) .....

PRE-PROCEDURE NURSING ASSESSMENT - COMPLETE BY ADMITTING NURSE

Procedure: ☐ Flexi Sig ☐ Colonoscopy ☐ Gastroscopy ☐ Other ..... Time: .....

RECORDINGS: BP: ..... / ..... Pulse: ..... 02 Sats: ..... BSL: ..... Temp: ..... Weight kgs: .....

Last food: Date: ..... Time: ..... **Last drink:** Date: ..... Time: .....

Labels and Identification Correct: ☐ Yes ☐ No **Did you drink all your bowel Prep** ☐ Yes ☐ No

Bowel motions ☐ Watery ☐ Lumpy ☐ Solid Enema Required ☐ Yes Number: ..... Result: .....

TICK APPLICABLE: ☐ Own Teeth ☐ Partial Plate ☐ Full Dentures ☐ Crowns ☐ Caps ☐ Hearing Aid

☐ Private X-Rays ☐ Spectacles/Contact Lens ☐ Walking Stick/Aid **Consent Signed:** ☐ Patient ☐ Specialist

Patient to be collected by: ..... Contact Phone No: .....

Nurse Name: ..... **Nurse Signature:** .....

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ENDOSCOPY PROCEDURE RECORD

Date: ..... Time In: ..... Time Out: .....

Endoscopist: ..... Endoscopy 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 mcg/IV									
	Midazolam mg/IV									
	Hyoscine mg/IV									
	Lignocaine Spray PO									
	IV Fluid IV									

UGI Start Time:	End Time:	Colon Start Time:	End Time:

OBSERVATIONS

Time														
O^2														
SaO^2														
Resps														
LOC														
220														
200														
180														
160														
140														
120														
100														
80														
60														
40														
20														
0														

LOC Guide A: Alert V: Verbal P: Painful Stimuli U: Unresponsive

BIOPSIES/POLYPS

	Bx	P		Bx	P		Bx	P
Oesophagus	☐	☐	H Pylori (HUT Test)	☐	☐	Descending	☐	☐
GO Junction	☐	☐	Terminal ileum	☐	☐	Left colon	☐	☐
Gastric	☐	☐	Caecum	☐	☐	Sigmoid	☐	☐
Antrum	☐	☐	Ascending	☐	☐	Rectum	☐	☐
Pylorus	☐	☐	Right colon	☐	☐	Other:		
Duodenum 1	☐	☐	Hepatic flexure	☐	☐	.....	☐	☐
Duodenum 2	☐	☐	Transverse	☐	☐	.....	☐	☐
Disaccharides	☐	☐	Splenic flexure	☐	☐	.....	☐	☐

ENDOSCOPY NURSING NOTES

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Abdominal Pressure: ☐ Yes ☐ No Name: ..... Time Required: .....

Restart anti-coagulant medication - Start Date: ..... Sign: .....

ENDOSCOPY TRACEABILITY STICKERS

ENDOSCOPE NUMBER

TRACEABILITY STICKERS

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RECOVERY

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

RECOVERY RECORD

Arrival Time
_____Hrs

On Admission
- Unconscious
- Conscious

_____Hrs

Anaesthetic
- General
- Local
- Block
- Sedation
- No Sedation

Airway
- None
- Oro
- LMA
- Jaw Support
- Other

- Hudson Mask
- N/Prongs

Resps
- Normal
- Shallow
- Low Rate
- Ventilatory Assistance

Time															
O^2															
SaO^2															
Resps															
200															
190															
180															
170															
160															
150															
140															
130															
120															
110															
100															
90															
80															
70															
60															
50															
40															
30															
LOC															
Pain Score															
Analgesia															

DISCHARGE SUMMARY		
Sip Test: Yes No	IV Luer:	IV Fluids:
Nurse's Signature	Discharge Time	Hrs

LOC Guide A: Alert V: Verbal P: Painful Stimuli U: Unresponsive Pain Score 0 No pain, 1 Mild, 2 Moderate 3 Severe

WARD NOTES

Ward Nursing - IV Cannula Insertion

Location: Right: ☐ ACF ☐ Hand Left: ☐ ACF ☐ Hand

Other: ..... Size: .....

Time: ..... Signature: .....

Ward Nursing Notes

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Observations: .....

Time: ..... BP: ..... HR: ..... SaO_2: ..... BGL: ..... mmol/L .....

.....

Time of Discharge: ..... Signature: .....

Discharge Checklist

- ☐ Tolerating Fluids/light diet
- ☐ Pain controlled
- ☐ Post-procedure instructions given
- ☐ Copy of Endoscopy report given
- ☐ Referral Form sent/ copy to patient
- ☐ Prescription (if applicable)
- ☐ Valuables returned to patient (if applicable)
- ☐ IV cannula removed
- ☐ Seen by Dr ☐ Yes ☐ No

Follow up phone call

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.....

.....

Date: ..... Time: ..... Nurses Signature: .....

Health Professionals Initials – Administrators/Checker

Name (Printed):	REG No.	Initials	Name (Printed):	REG No.	Initials

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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)

I ..... 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: .....