Consent Form for Gastroscopy and Sedation

To the Medical Director of Tokyo Midtown Medical Clinic

～Attention～
Please fill this form with a ballpoint pen.

ID:
名前:

I have read the below document and fully understood the purpose, content, and risks of the gastroscopy and sedation. I consent to undergo the procedure on my free will, with the understanding that the procedure results cannot be completely guaranteed, as the practice of medicine involves uncertainties.

(Please check the following items that apply ☑)

Understanding the contents of the gastroscopy guide

- ☐ 1. Purpose of exam
- ☐ 2. Procedure of exam
- ☐ 3. Precaution prior to exam
- ☐ 4. Precaution after exam
- ☐ 5. Complications and risks
- ☐ 6. Other precautions
- ☐ 7. Alternative examinations
- ☐ 8. Your right to withdraw consent
- ☐ Medications which must be discontinued before the procedure

I would like to proceed with the following procedure

- ☐ Nasal endoscopy ※Patients taking MAO inhibitors for Parkinson's disease may not undergo an endoscopy.
- ☐ Oral endoscopy
- ☐ Oral endoscopy with sedation (*I will not drink alcohol or drive vehicles until 6 am the next morning)
  - ☐ I do not have glaucoma
  - ☐ I have glaucoma (Please check the next section)

Patients with glaucoma (including suspected cases or high intraocular pressure) or increased cupping of optic disc

- ☐ I have consulted an ophthalmologist and have been permitted to undergo sedation.
- ☐ I have received permission from the ophthalmologist and I elect to undergo sedation.

※Please bring the relevant documents (medical certificate), or consult with an ophthalmologist in person or by phone.

[Date: Name of the Ophthalmology Clinic: Name of Doctor:]

Patients with high fall risk (e.g., use of wheelchair or cane, difficulty walking due to injury, illness, or age)

We recommend that somebody accompany you home since the sedation will further increase your risk of falling.

- ☐ I have a companion to go home with (your companion:_____e.g., husband)
- ☐ I understand all the risks mentioned above and I do not need a companion.

Patients with cerebral aneurysm 4 mm or larger

- ☐ I have consulted a neurosurgeon and have been permitted to undergo the endoscopy. (within 3 months of the endoscopy)
- ☐ I have received permission from a neurosurgeon, and I agree to undergo the endoscopy.

※Please bring the relevant documents (medical certificate), or consult with a neurosurgeon in person or by phone.

[Date: Name of the Neurosurgery Clinic: Name of Doctor:]

following next page

I consent to undergo biopsy, if an abnormality is found or suspected.

☐ I consent to a biopsy

※ With Japanese Health Insurance: approx. 4,000 – 15,000 yen (1 – 3 organs)

※ If you are covered by the Japanese Health Insurance but do not bring your insurance card, you will be charged the full price (Refundable by submitting your insurance card)

※ Without Japanese Health Insurance: approx. 35,000 – 100,000 yen (200% of fee)

☐ I do not want a biopsy (☐hemodialysis, ☐oral warfarin, ☐other_____)

Regarding teeth

☐ I understand that complications associated with the procedure can cause tooth damage regardless of the condition of the tooth (such as healthy teeth, loose teeth, dental crowns, or implants).

Patients with cancer (If you are undergoing chemotherapy or have cancer that is not cured)

☐ I have confirmed with my primary physician that I can undergo endoscopy and biopsy.

☐ Based on my primary physician's decision, I would like to undergo endoscopy and biopsy.

※ Please bring the relevant documents (medical certificate) or consult with your primary physician in person or by phone, regarding whether or not you can undergo endoscopy and biopsy.

[Date: Name of Clinic: Name of Doctor:]

Patients with neuromuscular diseases (myopathy, myositis, myasthenia gravis, etc.) ※No allowed endoscopy for patients with ALS.

☐ I have confirmed with my primary physician that I can undergo endoscopy and sedation.

☐ Based on my primary physician's decision, I would like to undergo endoscopy and sedation.

※Please bring the relevant documents (medical certificate) to undergo the endoscopy and sedation before the procedure.

[Date: Name of Clinic: Name of Doctor:]

Other conditions

☐ I have not had an abdominal surgery (laparotomy, laparoscopy, C-section) within 6 months

☐ I weigh less than 130 kg on the day of the examination

☐ My blood pressure value on the day of examination is less than BP180/110 mm Hg

☐ My intraocular pressure is less than 25 mmHg on the day of the examination and I do not have any eye pain.

☐ I am not actually or suspected of pregnancy.

(Signature of Explainer) ※staff use only
Doctor (or Nurse) in charge of explanation: Date & Time: Signature:
Endoscopist (or Nurse): Date & Time: Signature:
【Signature of Patient】
Date (yyyy/mm/dd) / / Time : Signature:
【If the patient is unable to consent, parent or legal guardian needs to sign】
Date (yyyy/mm/dd) / / Time : Signature: Emergency contact number (Relationship:)