

**THIS HAS BEEN PROVIDED FOR YOUR REVIEW.  
UPON ARRIVAL AT DIGESTIVE HEALTH ENDOSCOPY CENTER, YOU WILL BE ASKED  
TO SIGN AN ELECTRONIC VERSION OF THIS FORM**

**INFORMED CONSENT FOR COLONOSCOPY**

I authorize Dr. \_\_\_\_\_ and any assistant(s) deemed necessary to perform a **COLONOSCOPY WITH POSSIBLE BIOPSY AND/OR POLYPECTOMY.**

I understand that a colonoscopy allows my doctor to look inside of my large intestine (the colon). A colonoscopy is an excellent means to screen and monitor for colon cancer, helps my doctor in making the right diagnosis to manage bowel disease with symptoms such as blood in the stool, abdominal pain, constipation, diarrhea or other GI complaints.

I understand that for this procedure I will most likely rest on my side or back, my doctor will insert a lighted flexible tube (**colonoscope**) through my rectum and into the colon. My doctor will be able to see my colon on a screen throughout the procedure. If a problem spot is detected, a tissue sample (**biopsy**) will be taken for further testing. Often times abnormal growth of tissue (**polyps**) are found during the procedure, these are usually benign (not malignant or cancerous) but should be removed because they may have a focus of cancer. Most polyps can be removed at the time of the exam (**polypectomy**) and sent to the lab for further testing. Occasionally, a polyp is either too large or of such a type that it cannot be removed **at the time of the procedure**, if this happens, surgery may be advised.

I have been informed that according to my condition, I have **other alternatives** to a colonoscopy including a barium enema, a CT scan, a CT colonography, or stool testing (hemoccult). These alternatives may be useful and may give general information about problems within my colon, but they do not provide the in-depth information and direct visibility as the colonoscopy does.

I am aware of the **risks** associated with any endoscopic procedure. These risks have been explained to me by my doctor and may include but are not limited to: bleeding (immediate or up to 14 days after the procedure), missed polyps and/or cancer that may not be seen during the procedure, rectal irritation, medication reaction (to sedation, or any other medications administered), irritation of the vein used for IV medication, infection, tear or perforation of the colon and rectum, possibility of injury to the spleen, abdominal bloating and cramping. Rarely a complication may require additional treatment such as surgery, hospitalization, repeat endoscopy and/or blood transfusion. There is also a small risk of cardiopulmonary events such as loss of breathing and heart rhythm disturbances including rare cardiopulmonary arrest.

I consent to the use of medications administered by a licensed professional to provide me with **sedation**. This is used to relax me and minimize my discomfort during my procedure. I will be monitored throughout the procedure and in the recovery area until ready for discharge. Occasionally under certain circumstances the procedure may be performed without sedation at the discretion of my doctor.

I am advised that **if I am a female 50 years and younger**, I may be required to submit urine for **pregnancy testing**. I understand that if I refuse the test, the scheduled procedure may be cancelled. I understand that if I am pregnant or if there is any possibility, I may be pregnant I will inform the facility immediately since the procedure and medication administered could cause harm to my child or myself.

In the event that a nurse or physician **is/are exposed** to my blood or bodily fluids, I give my permission for my blood to be drawn and tested for HIV and Hepatitis to protect me and my caregiver.

I am advised that a responsible adult **MUST** drive me home and I **MAY NOT** be permitted to ride home alone in a taxi or bus. I have been advised by the facility personnel not to drive or work the day of the procedure. **Should I not have a driver, the procedure could be attempted without sedation or cancelled.**

I understand that, as stated on the **Patients' Rights and Responsibilities form**, if I experience cardiac arrest, respiratory arrest, or any other life-threatening situation while in the facility, I consent for resuscitation and transfer to a higher level of care. At the request of Digestive Health Endoscopy Center, I excuse Digestive Health Endoscopy Center from honoring my previously signed **Advanced Directives** throughout the course of care for this procedure.

By signing below, I confirm that the nature of the **COLONOSCOPY**, its indications, **and** alternative means of diagnosis or treatment, have been explained to me. I have also been informed of the potential risks involved and their possible consequences. I have read this information sheet regarding this procedure and have had the opportunity to discuss the above with my physician and he has answered all my questions to my satisfaction.

If I am not the patient, I represent that I have the authority and full rights of the patient who, because of age or other legal disability, is unable to consent to the matters above.

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Patient or Person Authorized to sign for patient

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Date (Relationship if other than Patient)

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Witness to Signature

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Date

I certify that I have explained the nature, purpose, benefits, risks, complications, and alternatives to the proposed procedure to the patient and/or their legal representative. I have given the opportunity to ask questions and all questions have been answered. The patient and/or legal representative has expressed understanding of what I have explained and agrees to the procedure.

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Physician signature

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Date