Informed Consent to Diagnostic or Therapeutic Procedures,
And Rendering of Other Medical Services

I authorize my physician, _____ and his / her assistants, as may be selected by him/her to perform the following procedure(s) and/or diagnostic procedure(s):

☐ Colonoscopy- Examination of the large intestine with a flexible tube passed through the anus (with possible biopsy and/or polypectomy and/or dilation) * The entire large intestine is usually examined. The lower small intestine may be examined.

☐ Upper Endoscopy- Examination of the esophagus, stomach, and duodenum with a flexible tube passed though the mouth (with possible biopsy and/or polypectomy and/or dilation)*

☐ Flexible Sigmoidoscopy- Limited exam of the lower GI tract (with possible biopsy and/or polypectomy)*

☐ Pouchoscopy- Examination of the ileo-anal pouch with a flexible tube (with possible biopsy and/or polypectomy)*

☐ Other: _____

Biopsy- The removal of small pieces of tissue for analysis

Polypectomy- Removal of small growths from the GI tract with special instruments

Dilation- Enlarging of a narrowed area

* Additional interventions deemed necessary by your physician may be required

Alternatives: X-Ray tests ("upper GI series" or "barium swallow") are sometimes recommended as alternatives. X-Ray tests ("lower GI series" or "barium enema") or surgery are sometimes recommended as alternatives. X-Rays are less likely to cause a complication but are less accurate for diagnosing important conditions, and do not allow treatment such as removal of growths (polyps) or biopsy. Surgery is more likely to cause a complication, and is often not necessary. No test at all is an option, but no testing carries risks of failure to diagnose or prevent serious disease. It is possible to perform this test without anesthesia.

Risks: Colonoscopy/Upper Endoscopy/Sigmoidoscopy/Pouchoscopy involves some risks. Complications may occur even when a procedure is properly performed. Major complications include perforation and bleeding. Treatment of these conditions may require surgery or colostomy. Minor complications include dental injury or sore throat.
This is a highly accurate procedure, but with any test there is a small chance of missing something.
All these complications are possible but occur with low frequency. Your physician will discuss this frequency with you, if you wish, with particular reference to your own indications for endoscopy and your present state of health.

Consent to Resuscitation:
I understand that even though the Physicians and Staff of this center respect my right to participate in decisions regarding my health care, the policy of this center is that all patients undergoing procedures will be considered eligible for life sustaining emergency treatments. The signed consent implies permission for resuscitation and transfer to a higher level of care.

Tissue Disposal:
I authorize the pathologist to use his/her discretion in the disposal of any tissue or growths removed during the procedure described above.

Consent for Transfer:
I understand that the procedure(s) performed on me at this Center will be performed on an outpatient basis and that the facility does not provide 24 hour patient care. If my attending physician, or a qualified physician in his absence, finds it necessary or advisable to transfer me from this facility to a hospital, I consent to the transfer.

Consent for Photography:
I consent to photography of the procedure for medical, scientific, or educational purposes, provided my identity is not revealed by the pictures or descriptive text accompanying them.

Discharge Instructions:
The discharge instructions have been reviewed with me and I understand them. I will receive a copy to take home with me when I am discharged.
I understand that at the time of discharge, I may still be feeling the effects of the sedation I received during my procedure and therefore agree to be accompanied by an adult I know and trust upon discharge.

Administration of Anesthesia:
The protocol of this center involves using short-acting sedative medications which provide ideal conditions for successful completion of the procedure and a more rapid recovery.
Risks, Benefits, and Alternatives of anesthesia will be reviewed by the anesthesiologist.

All of my questions have been answered to my satisfaction.

Signed by: _____

☐ Patient ☐ Parent / Guardian / Conservator / POA

I have informed the patient, answered their questions and obtained consent to the procedure listed above:
Obtained by (Gastroenterologist sign) _____ Date:_____ Time:_____

☐ Telephone consent obtained from: _____Reason: _____

Witnessed by: _____Date: _____ Time: _____