CONSENT FOR LOWER GASTROINTESTINAL ENDOSCOPY AND ANCILLARY PROCEDURES

I have asked my health care team to perform and consent (agree) to have a lower gastrointestinal endoscopy (colonoscopy or flexible sigmoidoscopy). I also agree to have my health care team perform other procedures or interventions if advised or found to be of need. These other procedures may include, but are not limited to:

- Biopsy / polypectomy (for the sampling of abnormal tissue or removal of polyps)
- Cautery, metallic clip placement, injection therapy, tattooing (to stop bleeding or to mark an area for locating polyps / lesions in the future)
- Dilation (stretching narrowed or scarred areas)

I also consent to being given medicine and fluids as needed or advised. These may help to provide sedation or keep me hydrated.

The physician performing this procedure is board certified or board eligible by the American Board of Internal Medicine – Gastroenterology. I understand that this procedure will be performed by or under the direction of:

Dr. _____________________

My doctor or my doctor’s healthcare team has talked with me about the reasons for this procedure. They also talked with me about the methods to be used and the purpose. We have also discussed other methods and treatments, if they are available.

I understand that for this procedure a small flexible tube with a camera and instruments will be placed into my anus and then advanced into the lower intestinal tract. I am aware that a colonoscopy and flexible sigmoidoscopy cannot rule out all diseases including polyps and cancer. I am also aware that a colonoscopy may not be able to be finished for certain reasons. Some examples include:

- Unique anatomy (the tube may not be able to go through the body as needed)
- Poor bowel preparation
- Discomfort during procedure
- Unable to provide safe or enough sedation.

If I have a flexible sigmoidoscopy, I also consent to extend the exam beyond the length of the sigmoid and descending colon, if my doctor finds the need to.

I was told some possible risks and complications of the procedure. Some include but are not limited to:

- Bleeding
- Infection
- Ulceration
- Perforation (tearing hole) of the gastrointestinal tract
- Damage to other organs beyond the gastrointestinal tract
Even though these risks are rare, these complications may include the need for:

- Hospitalization
- Blood transfusions
- Emergency surgery
- Could even result in death and/or disability.

I understand that sedation and other medicines given during the procedure have a slight risk of unwanted effects. Some reactions include and are not limited to:

- Allergic reaction
- Vein irritation
- Respiratory and cardiac depression
- Even death

I agree that any tissue or body fluids removed, or photos taken during the procedure may be examined, saved, or thrown away in any way that is proper for diagnosis and treatment.

I have discussed with my physician or staff the care or assistance I may need once I am discharged.

I have decided to continue with this elective procedure and understand that I may withdraw this consent and decline to have this procedure at any time before I receive any anesthesia.

_____________________________________   ________________________
Patient Name        Date

_____________________________________   ________________________
Patient Signature       Witness

_____________________________________   _______________________
Patient / Legal Representative     Date

_____________________________________   _______________________
Physician Signature       Date

Interpreter (if applicable) ___________________________