Consent for Colonoscopy

I hereby authorize Dr. _____and his/her assistants to perform my colonoscopy.

A. I understand that a colonoscopy exam involves insertion of a lighted instrument into the rectum and colon. I understand that biopsies (tissue samples) may be taken and that a polyp(s) may be removed and sent to a pathologist for analysis. I authorize my doctor to perform a colonoscopy and any other procedure that may become necessary for my well-being, including any intervention that might become necessary to remedy a condition that is discovered during the procedure.
B. I understand that a colonoscopy exam has serious risks even when performed absolutely properly by an experienced, certified physician. I understand that although it is impossible for my physician to inform me of every possible complication, the serious risks associated with the procedure include but are not limited to:
    - Perforation of the bowel possibly resulting in the need for immediate surgery
    - Bleeding related to biopsy or polypectomy possibly necessitating hospitalization, blood transfusions, repeat colonoscopy to stop the bleeding or surgery
    - Aspiration pneumonia caused by stomach contents traveling up into the back of the mouth and then down into the airway
    - Infection, phlebitis, and/or nerve injury related to the IV catheter or IV medications administered
    - Damage to the spleen as the scope is passed through the part of the colon adjacent to the spleen
    - Inflammation or infection of the colon or appendix
    - Heart or Breathing problems related to anesthesia
    - Death related to a complication of the procedure.

C. I understand that a colonoscopy test can miss polyps or cancer even when performed absolutely properly by an experienced certified physician.
D. I understand that there are tests besides colonoscopy that can screen for colon cancer or check the colon for abnormalities. I choose to have a colonoscopy instead of the tests listed below:

-Virtual Colonoscopy	-Stool genetic testing
-Stool testing for occult blood	-Flexible sigmoidoscopy

E. I consent to the retention or disposal of any tissue that may be removed during the colonoscopy.
F. I understand that, if necessary, my physician may request the presence or assistance of another doctor during my colonoscopy. Permission is granted for a manufacturer's

representative, for technical assistance, or a student, for continuing education, to be in attendance during my procedure if the situation arises.

G. I understand that if my physician or a member of the staff has exposure to one of my body fluids during the colonoscopy, I will need to have my blood tested for viral hepatitis and HIV.

H. I understand the surgical and/or diagnostic procedures performed on me at the Center will be done on an outpatient basis and the Center does not provide 24 hour patient care. If my attending practitioner or any other qualified physician in his/her absence, shall find it necessary or advisable to transfer me from the Center to another healthcare facility, I consent and authorize the employees of the Center to arrange for and effect the transfer.

I. I understand and agree that all practitioners who furnish services to me at the Center, including my physician, anesthesia provider, pathologist, and the like are independent contractors with me and not employees of the Center.

J. Anesthesia services are being provided by First State Anesthesia, and I will sign a separate consent for those services.

K. I understand the Mid-Atlantic Endoscopy Center's position on Advance Directives i.e. how decisions will be made for my medical care in the event that I become unable to relay my requests.

Patient Certification:

I certify that I understand and accept the information on this form, have been given opportunity to ask questions, and wish to proceed with a colonoscopy exam.

Patient/Legal guardian Signature: _____Date/time: _____

Witness signature:_____Date/time:_____

Physician Certification:

I certify that I have explained the colonoscopy procedure and its inherent risks to the patient, along with alternatives to the procedure, including doing no test.

Physician signature:_____Date/time:_____