RCRS
ROCHESTER COLON & RECTAL SURGEONS, P.C.
ROCHESTERCOLON.COM

CONSENT FOR COLONOSCOPY

I hereby give consent and authorize _____

to treat the following conditions:

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by performing the following procedure(s):

Colonoscopy: a flexible instrument is passed through the anus, into the rectum and colon. Sometimes it is possible to enter the end of the small intestine from the colon. Tissue samples (a biopsy) may be taken. Polyps may be removed; this sometimes involves cauterization techniques. Intravenous sedation is available to make the procedure more comfortable.

_____ 1. The care provider(s) have explained my condition to me and the potential benefits of having the above procedure. I understand that no guarantees have been made to me about the outcome of the colonoscopy. The alternatives to this procedure include:

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- Not performing the colonoscopy, you may refuse this procedure; further, some X-ray and surgical techniques are useful in evaluating the colon.

_____ 2. The care provider(s) have discussed with me the reasonably foreseeable risks of the procedure and that there may be undesirable results.

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Colonoscopic procedures are very safe exams with low rates of complication, on the average of less than one percent per year. The risk of complication may be higher in patients with advanced age or in patients with underlying diseases. The disease being evaluated and treated may also increase the rate of complication.

Some risks that are specifically related to colonoscopy include, and not limited to:

- Discomfort during the procedure
- Missing the disease, not detecting the condition, misdiagnosis, incomplete exam
- Allergic or adverse reaction to the sedative or other medications administered
- Perforation of the colon, which may require hospitalization, surgery, or disability
- Bleeding (hemorrhage) as a consequence of removing a lesion from within the colon, or from another intra-abdominal organ
- Infection; this could occur at the IV site, in the gastrointestinal tract, from perforation, or other
- Very rare complications include: Heart attack (myocardial infarction), change in heart rhythm or stroke; Aspiration (to swallow vomit into the lungs) and/or changes in breathing function, including respiratory arrest (stop breathing) or seizure.

_____ 3. I understand that during the procedure, a condition may be discovered which was unknown. I

Initial authorize the provider to perform additional or different treatments which are deemed necessary, in his or her judgment.

_____ 4. I consent to the administration of IV sedation as deemed most appropriate.

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_____ 5. Any tissue removed during the procedure may be retained or disposed of in accordance with

Initial clinical practice. (E.g. biopsy, polyps, fluid, other)

_____ 6. At the discretion of the physician, the presence of equipment personnel may be appropriate.

Initial At no time will these individuals personally participate in any procedure.

_____ 7. I have carefully read and fully understand this Informed Consent form and have had sufficient

Initial opportunity to discuss my condition and the above procedure(s) with the care provider and his/her associates. All of my questions have been answered to my satisfaction.

_____ _____

Signature of Patient Date Time

_____

Print Name of Patient

_____ _____

Signature of Power of Attorney (If patient unable to sign) Relationship to the Patient

ATTESTATION

A provider has discussed the planned procedure, its expected benefits, the potential complications and risks and possible alternatives and their benefits and risks with the patient or the patient's surrogate. In my opinion, the patient or the patient's surrogate understands the proposed procedure, its risks, benefits, and alternatives.

_____ _____

Signature of Care Provider Date Time

_____

Title