



Affix Patient Label

Patient Name:

Date of Birth:

Informed Consent for Colonoscopy

This information is given to you so that you can make an informed decision about having a **Colonoscopy possible biopsy possible polypectomy**.

A colonoscopy is an internal examination of your colon (large intestine) and rectum using a thin, flexible tube with a camera on the end (a colonoscope). You will be given medicine to help you relax and pain medicine during the procedure. Your doctor will insert the tube gently through your anus. Pictures may be taken which your doctor can see on a video screen. The scope is then moved into the beginning of the large intestine. Air is introduced into your large intestine to get a better view. Biopsies (small tissue samples) may be taken. Small growths called polyps may be removed during the procedure.

Reason and Purpose of the Procedure:

This test is performed to diagnose and treat your problem. It is also part of a cancer screening program.

Benefits of this Procedure:

You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- Your doctor may be able to diagnose and treat a specific condition.
- Early detection of cancer.

Risks of Procedure:

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

- **Hole or tear in the large intestine.** This may require additional surgery to correct.
- **Bleeding.** This may need further treatment or repair.
- **Nausea, vomiting, bloating or rectal irritation caused by medications taken to cleanse the bowel.** These are temporary.
- **Complications from sedation medicine.** These include low blood pressure and breathing problems including slow breathing and aspiration (choking on vomit). A reaction to the medication can cause throat spasms, and excessive sweating. You will be watched by a nurse and given oxygen to breathe.
- **Infection** that may require antibiotics.

Rare Risks of polyp removal:

- Infection at the removal site with possible abscess.
- Gas or air trapped under the skin.
- Entrapment of normal bowel in the tool (snare) used to grab and cut the polyp.

Risks Associated with Smoking:

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Smoking is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks Associated with Obesity:

Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks Specific to You:

Alternative Treatments:

Other choices:

- Barium enema: An X-ray exam that can detect changes or abnormalities in the large intestine (colon).
- Cologuard: A noninvasive colon cancer screening test that you can use in the privacy of your own home.
- Do nothing. You can decide not to have the procedure.

If You Choose Not to Have this Treatment:

- Your abdominal symptoms may not be properly diagnosed or treated.
- If you have bleeding, cancer, or any other undiagnosed problem, it may lead to death.
- Your physician can discuss any other treatments available for your particular symptoms.

General Information:

- During this procedure, the doctor may need to perform more or different procedures than I agreed to.
- Tissues or organs taken from the body may be tested. They may be kept for research or teaching. I agree the hospital may discard these in a proper way.
- Students, technical sales people and other staff may be present during the procedure. My doctor will supervise them.
- Pictures and videos may be done during the procedure. These may be added to my medical record. These may be published for teaching purposes. My identity will be protected.

By signing this form I agree:

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.



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- I have had time to speak with the doctor. My questions have been answered.
 - I want to have this procedure: **Colonoscopy possible biopsy possible polypectomy**
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- I understand that my doctor may ask a partner to do the procedure.
 - I understand that other doctors, including medical residents, or other staff may help with surgery. The tasks will be based on their skill level. My doctor will supervise them.

Provider: This patient may require a type and screen or type and cross prior to surgery. IF so, please obtain consent for blood/product.

Patient Signature _____ Date: _____ Time: _____

Relationship: Patient Closest relative (relationship) _____ Guardian

Interpreter's Statement: I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.

Interpreter: _____ Date _____ Time _____

Interpreter (if applicable)

For Provider Use ONLY:

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Provider signature: _____ Date: _____ Time: _____

Teach Back

Patient shows understanding by stating in his or her own words:

____ Reason(s) for the treatment/procedure: _____

____ Area(s) of the body that will be affected: _____

____ Benefit(s) of the procedure: _____

____ Risk(s) of the procedure: _____

____ Alternative(s) to the procedure: _____

Or

____ Patient elects not to proceed: _____ (patient signature)

Validated/Witness: _____ Date: _____ Time: _____