BRONSON	Affix Patient Label
	Patient Name: DOB:

Informed Consent Colonoscopy With Biopsies And Polypectomy

This information is given to you so that you can make an informed decision about your child having an **colonoscopy with biopsies and polypectomy.**

Reason and Purpose of the Procedure:
A **colonoscopy** is a test used to see the inside of the large intestine and lower end of the small intestine. This test uses a lighted tube that moves easily. This tube has a camera on it. This lets the doctor see swelling, ulcers, bleeding, polyps or small growths and other changes that may not show up on other tests. The doctor may also take tiny samples of tissue from different areas that can be looked at under a microscope. If abnormal tissue is found it will be removed at that time.

Benefits of this Procedure:
Your child's doctor cannot promise your child will receive any of this benefit. Only you can decide if the benefits are worth the risk.

Your child may receive the following benefits. A colonoscopy is done to:
- See the inside of the intestine and things that may not show up on other tests.
- Get samples of tissue from inside the intestine that can be looked at under a microscope.
- Remove any polyps found.
- Help with the treatment of diseases that were found.

Risks of Procedure:
No procedure is completely risk free. Some risks are well known. Some of these risks can happen even when all steps are taken to prevent them. There may be risks not included in the list that your child's doctor cannot expect.
- Bleeding. Sometimes it may need a transfusion.
- Infection. This may require the use of medicine.
- Bowel perforation (tear) happens rarely. This will require a stay in the hospital and may need surgery.

Risks Specific to your child:

_____

_____

_____

Alternative Treatments:
Other choices:
- Other tests can be done. These are not as correct in reviewing certain types of bowel problems.
- You can decide not to let your child have this procedure.

If you choose not to have this treatment for your child:
- Your child's doctor may not have the information needed to treat your child in the best way.

General Information:
- My child will get medicines to help control pain or anxiety related to the procedure.
- During the procedure the doctor may need to do more tests or treatment.
- Tissues 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.
- I have had time to speak with the doctor. My questions have been answered.
- I want my child to have this procedure: **Esophageal Dilatation with Biopsies**
- I understand that my doctor may ask another partner to do this surgery/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.

Parent/Guardian Signature_____Date:_____Time:_____

Relationship: □Patient □Closest relative (relationship)_____ □Parent/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

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 parent has agreed to procedure.

Parent 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

____ Parent elects not to proceed: _____ Date:_____ Time:_____

(parent signature)

Validated/Witness:_____ Date:_____Time:_____