	Affix Patient Label
	Patient Name: _____ Date of Birth: _____

Informed Consent
Endoscopic Ultrasound of Colon with possible Fine Needle Aspiration

This information is given to you so that you can make an informed decision about having an **Endoscopic Ultrasound of the Colon with possible Fine Needle Aspiration**.

For this test a long flexible tube is placed in your rectum. Ultrasound is used to create images. Images of the colon, walls of the rectum, lesions or lymph nodes in the area can be seen. The ultrasound uses sound waves to create visual images and help identify abnormalities. If a lesion needs to be biopsied, ultrasound will guide the thin needle. A pathologist is onsite to examine the samples.

Reason and Purpose of the Procedure:

This test is used to help your doctor diagnose and treat your problem.

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.

- Evaluating anal sphincters.
- Evaluating area surrounding the rectum.
- Examining nodules or 'bumps' that may be in the intestinal wall.
- Staging of cancers.

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.

Risks of this procedure:

- There is a risk that small abnormalities may not be seen and may be missed.

General Risks of Procedure:

- Bleeding. This may need further treatment or repair.
- Infection. You may need antibiotics.
- A tear in the colon. This may require surgery to repair.
- Reaction to the anesthetic may occur. The most common reactions are nausea and vomiting. In rare cases, death may occur. The anesthesiologist will discuss this with you.

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Risks Associated with Smoking:

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:


- Do nothing. You can decide not to have the procedure.

If You Choose Not to Have this Treatment:

- We may be unable to diagnose your problem.

General Information:

- During this procedure, the doctor may need to perform more or different procedures than I agreed to.
- During the procedure the doctor may need to do more tests or treatment.
- 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.

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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 to have this procedure: **Endoscopic Ultrasound of the Colon with possible Fine Needle Aspiration**
- 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: _____