Informed Consent for Procedure

It is very important that you understand and consent to the treatment your doctor is providing for you and any procedure your doctor may perform. You should be involved in all decisions concerning surgical procedures your doctor has recommended. Sign this form only after you understand the procedure, the anticipated benefits, the risks, the alternatives, the risks associated with the alternatives and all your questions have been answered.

I hereby authorize the physician, _____, any associates or assistants they deem appropriate ("Providers"), to perform the following procedure: _____.

Colonoscopy: With possible biopsy and/or polypectomy, dilation, removal of foreign body and control of bleeding.
About the Procedure: This procedure involves an examination of the lining of the colon, rectum, and possibly the terminal ileum of the small bowel. The procedure utilizes a long flexible tube with a fiber-optic light and camera on the end for visualization. If necessary, the physician will take small biopsies (samples of tissue), control bleeding, perform dilations, and/or remove polyps. Polyps are tumors (growths) of the bowel that can be benign, precancerous, or cancerous.

Flexible Sigmoidoscopy: With possible biopsy and/or polypectomy, dilation, removal of foreign body and control of bleeding.
About the Procedure: This procedure involves an examination of the inside lining of your lower large bowel. The procedure is performed to examine the inner surface and lining of the rectum and lower colon. The procedure utilizes a long flexible tube with a fiber-optic light and camera on the end for visualization. If necessary, the Providers will take small biopsies (samples of tissue), control bleeding, perform dilation, and /or remove polyps. Polyps are growths of the bowel that can be benign, precancerous, or cancerous.

Pouchoscopy: With possible biopsy and/or polypectomy, dilation, removal of foreign body and control of bleeding.
About the Procedure: This procedure involves an examination of the pouch that was previously surgically created to serve as a stool reservoir after removal of the large bowel. The procedure utilizes a long flexible tube with a fiber-optic light and camera on the end for visualization. If necessary, the physician will take small biopsies (samples of tissue), control bleeding, perform dilations, and/or remove polyps. Polyps are tumors (growths) of the bowel that can be benign, precancerous, or cancerous.

Esophagogastroduodenoscopy (EGD): With possible biopsy and/or polypectomy, dilation, removal of foreign body and control of bleeding
About the Procedure: This procedure involves an examination of the esophagus, stomach, and duodenum (the first part of the small intestine). The procedure utilizes a long flexible tube with a fiber-optic light and camera on the end for visualization. If necessary, the physician will take small biopsies (samples of tissue), treat bleeding vessels, perform dilation, and/or remove polyps. Polyps are tumors (growths) that can be benign, precancerous, or cancerous.
My physician has explained to me the nature and purpose of the procedure that will be performed. I understand that the practice of medicine is not an exact science, and I acknowledge that no guarantees

have been made to me concerning the results of this procedure. Additionally, I authorize the performance of any other procedures that in the judgment of my physician or other healthcare providers participating in the procedure deemed necessary for my wellbeing, including such interventions as are considered medically advisable to remedy conditions discovered during the procedure.

Risks: I understand that there are risks with any surgery or procedure, and it is impossible for the physician to inform me of every possible complication. The doctor has explained to me that there are risks and possible undesirable consequences associated with this procedure that may occur during the procedure or afterwards, ***including, but not limited to:***

• Pain, abdominal discomfort • Nausea and vomiting • Faintness or dizziness • Headache • Bleeding from a biopsy or polyp removal site • Infection • Intravenous site bruising, swelling, or infection. • Nerve injury related to IV catheter. • Failure of diagnosis or a misdiagnosis • Damage to teeth or jaw.	• Perforation of the esophagus, stomach, or intestine • Perforation or tear of the bowel/rectal wall, approximately 0.3% • Damage/injury to internal organs, including spleen. • Not being able to examine the entire bowel. • Missed polyps, growth, or bowel disease. • Aspiration • Adverse drug reaction • Cardiac or Respiratory complications • Stroke or Death

Additional information:
Independent practitioners: 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 practitioners exercising their independent clinical judgment. They are not employees or representatives (agents) of the surgery center.

In the event my physician, anesthesia provider staff, or other patient is exposed to my blood, bodily fluids, or contaminated materials I agree to allow testing that will determine the presence of HIV and Hepatitis. An accredited laboratory, at no cost to me, will perform all required laboratory tests.

I consent to the photographing and publication, for medical, scientific, or educational purposes, of the procedure to be performed, which photographs may include appropriate portions of my body, provided no identity is revealed by the pictures or by descriptive context accompanying them. Permission is granted for a manufacturer's representative, for technical assistance, or a student, or continuing education, to be in attendance during my surgery or procedure if the situation arises.

I consent to the disposal, use, retention or donation of all tissues, materials, and substances that would normally be removed in the course of the procedure. I consent to the use of these specimens collected as part of my clinical treatment, to advance medical education or research.

I consent to the performance of the planned procedure; or changes to the plan as may be considered necessary or advisable. I hereby certify that I have read this consent form (or had it read to me) and

that my physician has fully explained it to me. I have reviewed and understood the risks, benefits, and alternatives of the planned procedure. Available alternatives to the to the procedure include the following:

Alternatives to the Procedure: These alternatives ***might include but are not limited to*** not having the procedure, contrast barium enema, CT scan, and stool testing.

Risks to Alternatives: I understand the potential risks associated with the alternatives ***include but are not limited to:*** non- relief or worsening of symptoms, incomplete diagnostic information (x-ray images will only provide pictures of the shape of the bowel and do not allow tissue samples to be taken or removal of polyps), missed disease, delay in diagnosis, infection, and perforation.

I have reviewed and understand the comparative risks, benefits and alternatives associated with performing the procedure in an ambulatory surgery setting instead of in a hospital. Because the procedure is being performed in an ambulatory setting, I understand my physicians may decide to have me transported in an ambulance to the nearest hospital should a possible complication arise.

Certification of Patient:	**Certification of Physician:**
By signing below, I certify that I have had an opportunity to ask the physician all my questions concerning anticipated benefits, material risks, side effects, alternative therapies, and risks of those alternatives, and all my questions have been answered to my satisfaction. I acknowledge that the comparative risks, benefits, and alternatives associated with performing this procedure at an ambulatory surgery center instead of a hospital have been fully explained to me. _____ _____ _____ Patient Signature or Authorized Individual Date Time _____ (if no printed label) Printed Name of Authorized Individual Role of Authorized Individual: ☐ Parent ☐ POA/Legal Guardian ☐ Other: _____	I hereby certify that I have discussed with the individual granting consent, anticipated benefits, material risks, alternative therapies and the risks associated with the alternatives described in this consent. _____ Signature of Physician _____ _____ Date Time

- ☐ **The Patient/Authorized Representative has read this form or had it read to him/her.**
- ☐ **The Patient/Authorized Representative states that he/she understands this information.**
- ☐ **The Patient/Authorized Representative has no further questions.**

_____ _____ _____
_____

Date Time Signature of Witness Printed Name of Witness

USE OF INTERPRETER OR SPECIAL ASSISTANCE

An interpreter or special assistance (indicated below) was used to assist the patient/authorized representative in understanding and completing this consent form.

❑ Language (specify): _____ ❑ Sign Language ❑ Patient is sight impaired, and the form was read to the Patient/Authorized Representative ❑ Other (specify): _____	_____ Printed Name of Individual Providing Assistance _____ Title or Relationship to Patient _____ _____ Signature Date