

MEDICAL RECORD INFORMED CONSENT for Clinical Procedures and Treatments – Signature Form –

1. Operation or Procedure: (No abbreviations: Indicate Left or Right) _____

Colonoscopy with Possible Biopsy

2. Basic Description of Procedure/Treatment: (In language understood by the patient) Pass endoscope tube through the anus into the colon, to look at the colon. If polyps or abnormal tissue is seen or suspected, these will be sampled by pinch biopsy or removed by electrocautery.

3. Reason for Procedure: Find and remove abnormal tissue.

which will be performed by or under the direction of Dr. _____ or associates.

4. I request the performance of the above named procedure/treatment. I understand that additional procedures and or operations may be required based on the judgement of the above professional staff. I understand that this is a teaching facility. Medical students, healthcare trainees, or required associates may be involved with the procedure/treatment.

A. Benefits: Diagnosis of colon disease.

B. Risks/Complications: (most common) 1. Infection 2. Bleeding 3. Respiratory depression

4. Aspiration 5. Perforation 6. Death

C. Alternatives: 1. No procedure/treatment 2. Surgery 3. Imaging

D. Risks of non-treatment: Worsening of condition

5. The nature and the purpose of the procedure/treatment, possible alternative methods of treatment, the risks involved and the possibility of complications have been fully explained to me. I know that other complications not listed, may occur. I understand that no guarantees have been made to me concerning the results of the operation or procedure.

6. I request the administration of such anesthetic and/or invasive procedures as many be considered necessary or advisable in the judgement of the professional staff of the VASLCHCS. I understand that undergoing anesthesia and its associated procedures involves risks including but not limited to pain, possible paralysis or death. I have had the chance to discuss these and other risks of anesthesia with the anesthesia staff.

7. Exceptions to procedure/treatment or anesthetic if any, are: _____
(if none, so state)

8. Do you have a Living Will, Advance Directive? Yes No
I agree to suspend requests for treatment limiting measures during the procedure described above. Yes No

(Continued other side)

PATIENT'S IDENTIFICATION (For typed or written entries give:
Name – last, first, middle; date; hospital or medical facility.)

**Day of Procedure Correct-Site Verification Outside of OR Suite
(initials and time required):**

- a. Pt. verified self and site of procedure: Yes No
- b. Site marked by Practitioner _____ Time _____
- c. Time Out Verified: Yes No
- d. Signature: _____

