Department of Veterans Affairs

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: _____

9. I request that *blood or blood products* be given to me before or during this procedure/treatment if my doctor/dentist thinks I need them. I consent to the transfusion of all blood or blood products that may be related to my recovery from this procedure/treatment for a period of thirty days after. I know there is a small risk of allergic reaction during blood product usage. I also know that there is a very small risk of infection, including hepatitis (<1 in 60,000) and AIDS (<1 in 700,000).

I refuse the use of blood products except for: _____
(indicate which specific blood products may be used) *(sign here)*

10. Any tissues that are removed from my body may be examined and then disposed of by the hospital personnel or saved and used for teaching purposes.

11. I request if a medical device is implanted in my body, personal information (such as my name, social security number and necessary medical information), may be given to the maker of the device for quality control purposes.

12. I request that my identity be protected if video photography, audio recordings or other images of medical data are collected during this procedure/medical treatment. These may be placed in my permanent record. I agree that these images, recordings or data can be used for education, training or quality review.

13. This document of informed consent for the specific procedure/treatment described above will be valid for a period of thirty days from the date I sign it. Consent for a treatment plan that involves a series of treatments/procedures like chronic hemodialysis, chemotherapy, therapeutic phlebotomy and refractory transfusion will be valid for no more than one year from the date I sign.

SIGNATURES

1. COUNSELING DOCTOR/DENTIST: I have counseled this patient/surrogate as to the nature of the proposed procedure/treatment, including the indications for, the potential benefits of and the associated risks as described in this consent. The patient/surrogate is alert and has decision-making capacity.

_____ _____
(Legible Name of Counseling Doctor/Dentist) (Signature of Counseling Doctor/Dentist)

2. PATIENT/SURROGATE: The information contained within this consent form was given to me and discussed in language I understand. A translator was provided if appropriate. I understand the information and was able to ask questions. I understand if I refuse the treatment offered, this may affect the clinical outcome but does not prevent access to future health care.

_____
(Signature of Patient) (Date) (Time)

_____
(Signature of Witness, excluding members of Procedure/Treatment Team)

3. SURROGATE/SPONSOR/GUARDIAN: (This is required only if the patient is not able to give consent)

_____ _____ _____
(Legible Name of Surrogate) (Signature of Surrogate) (Date) (Time)

Authority: a. ☐ Durable Power of Attorney for Healthcare b. ☐ Guardian
c. ☐ Next of Kin d. ☐ Close Friend
Relationship to patient _____

_____
(Signature of Witness, Excluding Members of Procedure/Treatment Team)