

## ENDOSCOPY CONSENT

- SURGEON:**
- Rama Jager, MD, PhD
  - Shekar Narayanan, M.D
  - Arun Gowdamarajan, M.D

I, the undersigned, give my permission to the doctors of *Colon & Rectal Care, Inc* and to an assistant surgeon as deemed appropriate by the doctor, dependent upon the procedure, to perform the procedure(s) listed below.

**Please read, initial each section and sign below.**

\_\_\_\_\_ **TITLE:**

- Colonoscopy, Biopsy, Polypectomy and possible Enteroscopy:** Examination of the entire large intestine with use of a video colonoscope (long flexible fiber optic tube). Tissue samples are taken of any abnormal areas and polyps will be removed.
- Flexible Sigmoidoscopy, Biopsy, Polypectomy:** Examination of rectum and sigmoid colon with a lighted fiber optic tube
- Pouchoscopy:** Examination of pouch mucosa and surveillance of anal transition zone with flexible fiber optic tube.
- Upper Gastrointestinal Endoscopy, Esophageal Dilatation:** Examination of upper digestive tract with video endoscope. Dilatation of esophagus can be done if stricture or narrowing is found.

\_\_\_\_\_ **SPECIFIC RISKS:** *Potential risks and complications related to above procedures include but are not limited to:*

- Perforation of the lining of the digestive tract by the instrument, which could result in leaking of digestive products into body cavities and would require surgery and even the possibility of fecal diversion with temporary or permanent ostomy. (Statistically this occurs less than once in every 2,000 procedures.)
- Bleeding may occur from a biopsy site or where a polyp was removed that may require additional surgery.
- Injury to organs adjacent to the colon such as spleen or liver. (Statistically, this occurs less than once in 10,000 procedures.)

\_\_\_\_\_ **GENERAL RISKS:** *Other potential risks include but are not limited to:*

- Allergic reactions to medications
- Irritation of the vein where medications were injected
- Aspiration of saliva and/or stomach contents
- Infection or fever that may require antibiotics
- Complications from pre-existing heart or lung disease or diabetes
- Injury or death from either known or unknown causes

\_\_\_\_\_ **GENERAL UNDERSTANDING:**

- Colonoscopy will not detect 100% of polyps or cancer. There is always a risk of a neoplasm that is not identified. If new or persistent symptoms of rectal bleeding, abdominal pain or alteration of bowel habits, I must contact the office for further diagnostic evaluation.
- The above stated procedure is recommended to me with the intention that it may contribute to my welfare, yet there is no assurance or guarantee that the procedure will achieve that objective. There is no assurance or guarantee that the same condition for which the procedure was recommended will not recur or that other problems secondary to the procedure do not develop postoperatively.
- It is imperative that the preparation instructions be followed exactly (and even then, the colon may not be completely clear of stool, thus decreasing the quality of the exam).

\_\_\_\_\_ **CONCLUSION:**

- I am aware of the nature of the above procedure and possible benefits.
- I am aware of the potential risks and complications related to the above procedure.
- In the event my procedure has been scheduled at Surgery Center Plus, I understand that my physician has an ownership or investment interest in the health care entity to which I am referred. I acknowledge that any questions I may have regarding such interest will be explained and discussed with me in substance in order to concur knowledgeable, within reason, in accepting his referral for treatment. Further, I understand that I may choose to be referred to another health care entity without consequence.
- I am aware that I must bring a responsible adult driver to remain at the Center during the procedure and drive me home.
- I understand that if I am on any blood thinning medications I must obtain clearance from the ordering physician.

\_\_\_\_\_ I am aware that I may not eat, drink or smoke 8 hours prior to my arrival time for the procedure or it may be cancelled.

\_\_\_\_\_ I am aware that I may be charged \$300.00 if I fail to provide a 48 hour notice of cancellation of my procedure.

Patient/Legal Representative Signature: \_\_\_\_\_

Patient's Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Physician: \_\_\_\_\_

