

AUTHORIZATION AND CONSENT

785-004

Rev.3/2016

Consent for diagnostic/therapeutic procedure: I acknowledge that I have authorized and directed my physician, **Dr.** _____, and/or his/her associates to perform, the following diagnostic/therapeutic procedure(s) on me. My physician and or his/her designee have explained to me the nature of the procedure(s), the expected benefits or effects of the procedure(s), the medically acceptable alternative procedures or treatments, the risks and hazards inherent in the proposed procedure(s).

COLONOSCOPY with, possible dilation, possible polypectomy, possible biopsy, possible control of bleeding. And/or any other therapeutic procedure(s) upon me, which he/she may deem necessary or advisable.	ESOPHAGOGASTRODUODENOSCOPY (EGD) with, possible dilation, possible polypectomy, possible biopsy, possible control of bleeding. And/or any other therapeutic procedure(s) upon me, which he/she may deem necessary or advisable.
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RISKS INCLUDE BUT ARE NOT LIMITED TO: PERTAINS TO ALL PROCEDURES:

Respiratory depression and cardiac rhythm disturbances due to the administration of sedatives- the risk of these problems occurring is 0.5%: approximately 0.08% of patients may experience aspiration pneumonia which has an associated death rate of 10%. There is a 3% risk of spreading bacteria into the blood from the Colonoscopy- this generally does not pose a clinical problem unless you have an artificial heart valve or severe valvular heart disease. There is the possibility of experiencing a rare allergic reaction to the medications to achieve sedation. Patients may also develop phlebitis, which is an inflammation of the intravenous site.

RISKS FOR COLONOSCOPY:	RISKS FOR EGD/DILATION:
There are no cases of the AIDS virus being transmitted by the colonoscope; there is a 0.2-0.4% risk of perforation of the colon with this procedure, and may require hospitalization with administration of antibiotics and intravenous fluids and on occasions surgical treatment. The risk of bleeding from diagnostic Colonoscopy is rare. There is a possibility of a ruptured spleen. This may require hospitalization with the administration of antibiotics, intravenous fluids, and may require the removal of the spleen. The miss rate of colonoscopy is up to 27% for small polyps and 6% for lesions greater than 10 mm. If a polyp is found in the colon, an attempt will be made to remove the polyp with a snare and electrocautery-this procedure carries a perforation risk of 0.3%-1% and a bleeding rate of 0.7-2.5%. The bleeding may occur up to two weeks following the removal of the polyp due to sloughing of the scab at the polypectomy site. There is a rare incidence of death following Colonoscopy and polypectomy. If a balloon dilatation of a surgically induced stricture is recommended, this carries a perforation rate of 4.6%.	Esophageal dilatation may carry a rate of bacteria seeding the blood stream in up to 4.5% of the cases; generally this is not a clinical problem unless you have an artificial heart valve or severe valvular heart disease. Following EGD/dilatation, other rare risks include: symptoms of chest or abdominal pain, bleeding or perforation (0.4-2.2%); this may require hospitalization, antibiotic administration, intravenous fluids, and may require surgical intervention to repair a tear in the esophagus, or may require a pyloroplasty. Bruising or a small tear in the inside of the lip may occur. Crown, carious or loose teeth, and dental appliances may be damaged if you bite down on the plastic airways or mouth-piece that will be placed in your mouth during your procedure. We cannot be held responsible for this type of damage.
BENEFITS: COLONOSCOPY involves the passage of a flexible lighted tube, the diameter of one's index finger, into the rectum. The tube is advanced to the beginning of the colon and then carefully withdrawn to determine if you have any growths or bleeding lesions in the colon. If such lesions are found, appropriate treatment can be applied to improve your health. Colonoscopy is the most accurate test for detection of colon lesions.	BENEFITS: EGD/DILATION involves the passage of a flexible lighted tube, the diameter of one's index finger into your mouth. The tube is advanced to the duodenum and carefully withdrawn to determine if you have any growths, strictures or bleeding lesions. If a stricture is found in your esophagus, outlet to your stomach, or a previous surgical anastomosis, then a dilatation would be performed to dilate narrowing's at these locations to provide you with the ability to once again consume food. If any lesions are found, appropriate treatment can be applied to improve your health. Esophagogastroduodenoscopy is the most accurate test for the detection of lesions.
ALTERNATIVE OPTIONS TO COLONOSCOPY: The alternative is a barium enema. This is an x-ray, which is not as accurate as a Colonoscopy in picking up growths in the colon and provides no therapeutic advantage. If a growth is found in the colon during a barium enema, then a Colonoscopy will be necessary to attempt to diagnose and perhaps remove the growth.	ALTERNATIVE OPTIONS TO EGD/DILATION: The alternative is a barium swallow. This is an x-ray, which is not as accurate as an EGD in picking up growths or bleeding lesions. If such growths or lesions are found, appropriate treatment can be applied to improve your health. Biopsies or treatment of bleeding ulcers can only be provided by EGD or major surgery.

- TISSUE DISPOSAL:** I hereby authorize the pathologist to use his/her discretion in the disposal of any severed tissue, removed from me during the procedure described above.
 - CONSENT TO TRANSFER:** I understand that the diagnostic procedure to be performed on me at the Endoscopy Center will be done on an outpatient basis and that the Endoscopy Center does not provide for 24-hour patient care. If my physician, or any other physician in her/his absence, shall find it necessary to transfer me from the Endoscopy Center to a hospital. I hereby consent and authorize the employees of the Endoscopy Center to arrange for and affect the transfer.
 - PHOTOGRAPHIC AUTHORIZATION AND RELEASE:** Gastrointestinal photographs may be taken during the above-described procedure and used in any medical, scientific, or educational manner that my physician and North Florida Endoscopy Center may deem proper. These photographic records and/or videos will be given to the physician whose name appears above for her/his disposal.
 - RELEASE OF RESPONSIBILITY FOR VALUABLES:** I have been given an opportunity to deposit valuables and money for safekeeping. It is understood that The Endoscopy Center assumes no responsibility for personal property such as dentures, clothing, jewelry, and other personal items retained by the patient.
- I certify that, based upon the information provided by my physician and/or her/his designee, I have a general understanding of the Sedation plan and procedure(s) to be performed on me and that no warranty or guarantee has been made as to the result or cure.**

Signature of patient or patients guardian _____ (Signature of witness) _____ Witness (signature only) _____ / / :
 (If patient is unable to sign) _____ Date Time

I attest that I, and/or one of my designee explained the Risks, Benefits, and alternatives of the procedure(s) named above with the patient. _____ MD / / :
 Date Time

PATIENT LABEL:

COLONOSCOPY/EGD/DILATION