HOWARD K. BERG, M.D.
CONSENT FOR COLONOSCOPY

Name of Patient:_____ Date:_____ AM/PM

1. My doctor has recommended the following procedure: **COLONOSCOPY WITH POSSIBLE POLYP REMOVAL AND/OR BIOPSY.** A Colonoscopy is a way of directly inspecting the inside of the colon and rectum. A long, flexible, lighted tube (colonoscope) is used to diagnose problems of the colon and rectum, perform biopsies, and remove colon polyps.

2. **CONSENT:** I consent to have the procedure described above performed by my doctor as the surgeon-in-charge. The surgeon-in-charge may designate other medical personnel to assist in the procedure. I consent to the photographing of appropriate portions of my colon or anorectum, for medical or educational purposes. I consent to the administration of such analgesics, sedatives, and/or anesthetics as deemed advisable with the exception of any stated allergies. In the event of an accidental exposure of my blood or bodily fluids to a physician, contractor, or employee of the facility, I consent to testing for HIV and Hepatitis.

3. **INDICATIONS FOR PROCEDURE:** The reason for this procedure is to evaluate your symptoms, an abnormal test, or to determine whether a polyp, cancer, or inflammation may be present.

4. **METHOD, ALTERNATIVES, AND RISKS:** The doctor has explained the details of the procedure (including conscious sedation), alternatives, outcomes, and associated risks and possible complications to me, to my satisfaction. Alternatives include: No evaluation; X-ray evaluation (Barium Enema); or Empiric treatment with medication. I understand that every conceivable risk and complication could not be explained to me. The main complications specific to this procedure are as follows:

A. **BLEEDING:** (Approximate risk less than 0.5%). This may result in the need for a blood transfusion. This carries the risks of transfusion reaction, hepatitis, or AIDS (Acquired Immune Deficiency Syndrome).

B. **PERFORATION (TEAR/PUNCTURE):** (Approximate risk less that 0.5%). On rare instances the bowel may be injured; requiring hospitalization, bowel rest, IV fluids, and antibiotics. Surgery may be needed to repair the injury. This may involve direct repair of the perforation, removal of a portion of the colon, and/or a temporary ostomy (opening of the bowel onto the skin with stool emptying into a bag).

C. **INFECTION:** A biopsy, polyp removal, or small tear may result in an infection (abdomen/pelvis, colon/rectum, heart valves, or other sites) which could require hospitalization and antibiotics.

D. **ALLERGIC REACTION TO MEDICATIONS** (sedating medicines, antibiotics, etc.)

E. **DEVELOPMENT OF ABNORMAL HEART RHYTHM, HEART ATTACK, LOW OR HIGH BLOOD PRESSURE**

F. **RESPIRATORY FAILURE: Inability** to adequately breathe or asthma.

5. **NO GUARANTEE:** No guarantee has been made to me about the outcome of the procedure. I understand that sometimes it is not successful. Occasionally, the rectum and entire colon may not be able to be examined (incomplete colonoscopy) and additional testing, such as a Barium Enema, may be necessary. Additionally, the problem may not be seen (i.e. a polyp, cancer, etc. may be missed) or the polyp not able to be retrieved for evaluation. Undergoing a colonoscopy does not guarantee that you will not develop a colon or rectal cancer in the future.

6. **COMPLICATIONS AND UNFORESEEN CONDITIONS:** I consent to any additional procedure that good medical judgement indicates should be performed to deal with any complication or unforeseen condition, if it seems medically undesirable to delay the procedure until my further written consent has been obtained.

7. **TISSUE:** I consent to the study, use, and disposal by Hospital of any tissue or parts, which may be necessary to remove.

8. **PREGNANCY:** I certify that to the best of my knowledge I am not pregnant. I understand that a colonoscopy, surgery, or X-rays may harm unborn children. I understand that by signing this consent form I am agreeing to inform my doctor immediately if I learn I am pregnant after signing this form.

9. **CERTIFICATION:** By signing this form I certify that I have had my eighteenth (18th) birthday or I am married, pregnant or a parent.

PLEASE DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT, UNDERSTAND IT AND AGREE WITH WHAT IT SAYS.

PATIENT'S SIGNATURE: WITNESSED BY:

Patient Name Date

Date

I, or my staff, have explained the above information to the patient, and believe that he/she understood our discussion. The patient was given a Colonoscopy educational pamphlet, and offered a copy of this consent form.

Howard K. Berg, M.D., FACS, FASCRS