Disclosure and Consent for Endoscopic Procedures

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you: it is simply an effort to make you better informed so that you may give or withhold your consent to the procedure.

1. I voluntarily request and authorize Dr. _____and such associates, technical assistants, and other health care providers as necessary to treat my condition which has been explained to me as:

_____

2. I understand the following procedure is planned for me and I voluntarily consent and authorize these procedures.

FLEXIBLE SIGMOIDOSCOPY: *A flexible lighted instrument will be passed through my anus and advanced through my lower colon to visually examine it. Dilation (stretching) may be performed as needed.*

3. I understand that pieces of tissue may be removed for further analysis, photographic pictures may be obtained, and other/ additional procedures may be performed at the discretion of the doctor for any unforeseen condition that arises in the course of the procedure. I further request and authorize the doctor to do whatever he/she deems advisable during my procedure. I also consent to the disposal by authorities of North Idaho Endoscopy Center of ay tissues or parts that may be removed.

4. Just as there may be risks and hazards in continuing my present condition without therapy, there are risks and hazards related to the performance of the planned endoscopic procedure. I realize that the risks associated with any invasive procedure include the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reaction, and even death. I also realize the risks which may occur in connection with this particular procedure include but are not limited to;

Perforation *which may require surgery / colostomy;* ***Bleeding*** *which may require blood transfusions;* ***Discomfort****: and* ***Diagnostic error***

5. I understand that no warranty, guarantee, or assurance has been made to me as result or cure

6. I understand that sedation involves additional risks and hazards, but I may request the use of sedation for the relief and protection from pain during the planned or any additional procedures. I understand that certain complications may result from the use of sedatives to include respiratory problems,, drug reactions, paralysis, brain damage or even death.

7. Alternatives to the planned procedure have been explained to me and include, but are not limited to: ***Barium enema, Rigid Proctoscopy, and Observation (do nothing).*** Just as there are risks and hazards to the planned procedure, I realize that risks and hazards may occur in connection with the alternatives and include, but are not limited to:
Failure to diagnose, radiation exposure, perforation, discomfort, etc.

8. In the event of an urgent or emergent transfer to another medical facility or health care provider, I authorize North Idaho Endoscopy Center to transfer all medical records, photographs, finding, etc. that North Idaho Endoscopy Center deems necessary to allow adequate subsequent medical care.

9. I certify that I have read (or have had it read to me) and fully understand the above consent for procedure, that the explanations therein referred to were made, and that all blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any were stricken before I signed it. I have been given the opportunity to ask questions regarding all aspects of this consent and I have sufficient information to give this informed consent.

PATIENT / LEGAL GUARDIAN:_____ DATE:___/___/___ TIME:_____

RELATIONSHIP TO PATIENT_____ WITNESS_____

PHYSICIAN:_____

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