

ARAPAHOE GASTROENTEROLOGY
ARAPAHOE ENDOSCOPY CENTER

INFORMED CONSENT FOR COLONOSCOPY

1. I, _____ authorize Dr. _____ and any assistant(s) he/she deems necessary to perform: Colonoscopy with possible biopsy or polyp removal with possible coagulation/injection therapy of blood vessels or tissue, and _____.
2. I understand this procedure involves the following: Passage of digital optic instrument through the rectum to allow the physician to visualize the interior of my large intestine (colon). Sedation and pain relieving medication(s) may be given to minimize discomfort and relax me for the procedure. These medications may cause localized irritation and/or a drug reaction may occur.
3. **RISKS:** Possible complications of this procedure include but are not limited to: Bleeding, tearing or perforation of the bowel wall. These complications, should they occur may require surgery, hospitalization, repeat Colonoscopy and/or a transfusion.

Other risks which can be serious and possibly fatal include: difficulty breathing, heart attack and stroke. These risks are extremely rare but may occur. Polyps (especially small ones) can be missed 5-10% of the time, and in rare cases, a colon cancer can be missed. Perforation of the bowel, which occurs at a rate of 1 per 1,000 Colonoscopies may occur. Bleeding, usually after polyp removal can occur 1% of the time and up to 2 weeks after a polyp is removed. Colonoscopy does not guarantee that you will not develop colon cancer, but removing polyps is documented to significantly decrease your risk of colon cancer in the future.

4. I understand that there are no guarantees regarding the results of this procedure. Alternatives are: _____.
5. I have read and fully understand this consent form, and understand I should not sign this form if all items, including all of my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form. **IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED PROCEDURE OR TREATMENT, ASK YOUR PHYSICIAN NOW, BEFORE SIGNING THIS CONSENT FORM. DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.**

Witness

Patient/Responsible Party

Date/Time

6. **PHYSICIAN DECLARATION:** I have explained the contents of this document to the patient and have answered all the patients' questions. To the best of my knowledge, I feel the patient has been adequately informed and has consented.

Physician's Signature

Date/Time