**ABILENE ENDOSCOPY CENTER**
**INFORMED CONSENT**

**PATIENT**________________________________________________________________________________
**Last** **First** **Middle Initial**

I voluntarily authorize ____________________________________ and associates, technical assistants and other health care providers as they may deem necessary, to perform the following diagnostic, medical or surgical procedure(s): **COLONOSCOPY WITH POSSIBLE BIOPSY AND POLYPECTOMY.**

**COLONOSCOPY: Your physician passes a flexible instrument into the rectum to allow examination of all or a portion of the colon. Polypectomy (removal of small growths called polyps) is performed if necessary by the use of a wire loop and electric current. If a bleeding site is found coagulation by heat may be performed. If indicated, biopsies may also be obtained though all are accompanied by a slightly greater risk of bleeding or perforation.**

**ALTERNATIVES TO GASTROINTESTINAL ENDOSCOPY:** Although gastrointestinal endoscopy is an extremely safe and effective means of examining the gastrointestinal tract, it is not 100 % accurate in diagnosis. In a small percentage of cases a failure of diagnosis or a misdiagnosis may result. Some alternatives, other diagnostic or therapeutic procedures, such as medical treatment, X-ray and surgery are available. Another option is to choose no diagnostic studies and / or treatment. Your physician will be happy to discuss these options with you.

1. I understand that there are risks and hazards related to the procedure such as damage to the lining from the instrument, aspiration, reaction to medications, gas pains, perforation of colon, bleeding, infection, or complications from other disease you may already have and as with any procedure there is a remote risk of death.
2. I consent to the administration of moderate sedation as may be considered necessary. I understand that moderate sedation involves additional risks and hazards but I request the use of sedation for the relief from pain during the procedure(s). I understand that certain complications may result from the use of moderate sedation including respiratory problems or drug reaction.
3. I authorize the doctor(s) to perform any other procedure that their judgement may dictate to be necessary or advisable should unforeseen circumstances arise during the procedure.
4. In the event the physician or staff is exposed to my blood, body fluids or contaminated materials, I agree to allow testing that will determine the presence of HIV and Hepatitis. An accredited laboratory, at no cost to me, will perform all required laboratory tests.
5. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me about the results or success of this procedure
6. In the event of a life threatening event, emergency medical procedures will be implemented, the patient stabilized and transferred to an acute health care facility where the decision to continue or terminate emergency measures can be made by the attending physician and family.

*I am stating that I have read this consent (or it has been read to me) and I fully understand it and the possible risks, complications and benefits that can result from the procedure(s). I accept on behalf of myself / this patient all of the items listed in these paragraphs.*

____________________________________________ ________________________________
Patient or Legal Guardian/Representative Signature Relationship/Date

____________________________________________
Witness to Signature Date/Time

1/10/2014