Central Illinois Endoscopy Center

Colonoscopy Informed Consent Form

I _____ D.O.B. _____ do hereby authorize _____,MD, and any assistant(s) he/she may designate to perform upon me the procedure of : Colonoscopy WITH POSSIBLE BIOPSY AND /OR POLYPECTOMY with the accompanying moderate sedation/analgesia as necessary.

1. I understand that this is a procedure performed to examine the inside of my colon, or large intestine. The examination uses a long, flexible, fiberoptic lighted tube that allows for viewing inside of the colon in order to evaluate its health and diagnose conditions affecting your colon.
2. I understand that this procedure may not be able to be completed due to poor bowel preparation, bowel disease or other problems.
3. I understand that the procedure is generally safe, but certain risks accompany any endoscopic procedure. The risks of a Colonoscopy include but are not limited to:
   - Perforation (a hole is created in the lining of the colon) this may require surgery to repair. The risk is increased when there is a biopsy taken or a polyp removed.
   - Bleeding. The risk is increased when there is a biopsy taken or a polyp removed. This can happen up to 10-14 days following the procedure. Blood transfusion may be needed if there is a lot of bleeding and may even require another colonoscopy or surgery to stop bleeding.
   - Discomfort. A small possibility that you cannot be completely sedated and therefore may experience some pain and discomfort during the procedure.
   - Reactions to the IV sedative drugs/topical anesthetic spray including but not limited to rash, low blood pressure, breathing difficulty, irritation of the skin, and impaired oxygen delivery.
   - Rare, unusual reactions, such as splenic injury, including possible death, following any endoscopic procedure.
   - Infection.
4. I understand that the practice of medicine is not an exact science, and that no guarantee can be made regarding the outcome of my planned procedure.
5. I understand there are alternatives to this procedure including: barium enema, colonoscopy, flexible sigmoidoscopy and virtual colonoscopy.
6. I understand that if any immediate life-threatening events happen during the procedure, they will be treated accordingly.
7. I understand that a Colonoscopy is not completely accurate and occasionally abnormalities including cancers and polyps may be missed.
8. I understand that a Colonoscopy with polypectomy does not provide 100% protection against colon cancer.
9. A resident (doctor still in training) may participate in my procedure, as well as the extent of the resident's participation and I have agreed to the resident's participation. I understand that I may refuse to be involved in the formal training of medical and other students without this affecting my care and treatment in a negative way.
10. I consent to the entering of authorized personnel and observers including students to the procedure room.
11. I consent to the photographing, videotaping, audio or other digital recordings, or televising of the operations or the procedures to be performed including necessary portions of my body for medical, scientific or educational purposes. I understand that my identity will not be revealed by the pictures or by writing that accompany them and I have the right to request the stopping of any recording or filming. I consent to the pictures or by writings that accompany them and I have the right to request the stopping of any recording or filming.
12. By signing (will signed at office prior to procedure) this I acknowledge that I have received and been given verbal instructions on the following forms: Physician Ownership Disclosure Form, Patient Rights and Responsibilities, Patient Privacy and Advance Directives.
13. **I CERTIFY THAT I HAVE READ OR HAD READ TO ME THE CONTENTS OF THIS FORM. I UNDERSTAND THE RISKS, SIDE EFFECTS AND ALTERNATIVES INVOLVED IN THIS PROCEDURE. I HAVE HAD THE OPPORTUNITY TO ASK ANY QUESTIONS WHICH I HAD AND ALL OF MY QUESTIONS WERE ANSWERED.**

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PHYSICIAN OWNERSHIP DISCLOSURE FORM

In accordance with Federal ASC Regulations (42 C.F.R. 416.50(a)(ii)), the following ownership disclosure is made in advance of the date of the procedure:

Central Illinois Endoscopy Center is owned in part by the physicians of Illinois Gastroenterology Institute. The physician who will be performing your procedure is an owner of that practice.

You have the option to be treated at another health care facility such as OSF Saint Francis Medical Center, Unity Point - Methodist, or Unity Point - Proctor.