Consent for Colonoscopy and Conscious Sedation

**Procedure Consent:** I authorize Dr. _________________________ to perform a colonoscopy and other procedures, such as biopsy, polyp removal, dilation of narrowed areas, control of bleeding, etc., as deemed necessary and appropriate during the colonoscopy. I authorize sedation and other medications to be administered intravenously as needed to control my comfort, blood pressure, etc.

**Colonoscopy:** involves looking into the large intestine (colon) using a flexible instrument referred to as a scope to visually examine the lining within the colon. The scope enters through the anus, into the rectum and through the large intestine and sometimes enters the very beginning of the small intestine. Tissue samples (a biopsy) may be taken and polyps (abnormal growths) may be removed. This sometimes involves cauterization techniques to control bleeding. Intravenous sedation is available to make the procedure more comfortable. Other medications such as pain relievers and anti-spasmodics (used to slow movement of the colon to allow better visualization), are given intravenously to improve the quality of the examination and to reduce discomfort and anxiety. Diagnoses are made by visual inspection and by taking small samples (biopsies) of tissue for examination under a microscope.

**Colonoscopy Risks:** colonoscopy procedures are common with a low rate of complication, on the average of less than one percent per year. The risk of complication may be higher in patients with advanced age or in patients with underlying diseases. The disease being evaluated and treated may also increase the rate of complication. Some risks that are specifically related to a colonoscopy include, but are not limited to: discomfort during the procedure; phlebitis (irritation of a vein); missing abnormalities, misdiagnosis, incomplete exam; allergic or adverse reaction to the sedative or other medication administered; perforation of the colon, which may require hospitalization or surgery; bleeding as a result of removing tissue, such as a polyp from within the colon; infection at the IV site, within the colon or other organs caused by perforation or other causes. Very rare complications include: heart attack, change in heart rhythm or stroke, aspiration (to swallow vomit into the lungs) and/or changes in breathing function, including respiratory arrest (stop breathing) or seizure.

**Alternatives to Colonoscopy:** alternatives range from doing nothing, to performing surgery or to performing other kinds of diagnostic tests (such as x-rays).

**Emergency Care:** if an emergency should arise which require additional procedures or medications, I authorize my physician and his/her designees to do whatever they deem advisable in my best interest. I authorize transfer to a hospital for in-patient care, if warranted by my condition.

**Acknowledgements:** I acknowledge that I am not to drive a motor vehicle for 24 hours if I receive conscious sedation medication, that no guarantees or warranties have been made concerning the colonoscopy, and that I have had an opportunity to discuss concerns regarding the colonoscopy with my physician and to have my questions answered.

By signing below, I am indicating that I have read and understand all of the information on this form and that I am consenting to receive a colonoscopy procedure to be performed by my physician at Desert Sun Surgery Center.

___________________________________________________  ____________________________  ____________________________
Patient or Authorized Agent Signature            Date   Staff Witness Signature

*Do not sign this form until the day of your procedure and in the presence of a Desert Sun representative.*