



LONGMONT SURGERY CENTER, LLC

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Informed Consent for Colonoscopy

I, \_\_\_\_\_ (Patient or Guardian)

authorize \_\_\_\_\_ M.D., to perform the following Procedure(s) at Longmont Surgery Center:

- Colonoscopy to include biopsy
• Removal of polyps
• Coagulation/Injection Therapy of blood vessels or tissue
• Conscious Sedation

- 1. I understand this procedure involves the following: Passage of a fiber-optic scope through the rectum to allow the Physician to visualize the interior of my large intestine (colon). I understand conscious sedation may be given to minimize discomfort and relax me for the procedure. Conscious sedation involves additional risks and hazards; however, I request the use of sedation for the relief from pain during the procedure(s). I authorize the pathologist to dispose of any tissue at his discretion.
2. RISKS: Possible complications of these procedures include, but are not limited to infection, bleeding, tearing, or perforation of the intestine. These complications (estimated 0.2 to 1%), should they occur it might require surgery and/or transfusion. I understand that certain complications may result from the use of conscious sedation including respiratory problems or drug reactions. Other risks that can be serious and possibly fatal include aspiration, difficulty breathing, heart attack and stroke. These are extremely rare but may occur. As it is important to state every complication that may occur as a result of surgery the risks lists are incomplete.
3. The risks, benefits and alternatives have been explained to me and I have had the opportunity to have my questions answered. 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 misdiagnosis may result.
4. I understand that in the event the Physician or staff is exposed to my blood, body fluids or contaminated material, I agree to allow testing that will determine the presence of HIV or Hepatitis. An accredited laboratory, at no cost to me, will perform all required laboratory testing.
5. I consent to endoscopic photographs during the procedure and release the Longmont Surgery Center from ANY liability from claims of any kind for use of photographs.
6. I understand that if I have a Living Will or Durable Power of Attorney or Advanced Directive they will NOT be honored at the Longmont Surgery Center.
7. If it is necessary for me to be transported I release the Longmont Surgery Center from any and all responsibility for care rendered to me at another facility.
8. I have read and fully understand this consent form and understand I should not sign this form if all items, including 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.

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 AND/OR THIS PATIENT ALL OF THE ITEMS LISTED IN THESE PARAGRAPHS.

Time: \_\_\_\_\_ Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Witness to Signature: \_\_\_\_\_

PHYSICIAN DECLARATION: I HAVE EXPLAINED THE CONCERNS OF THIS DOCUMENT TO THE PATIENT/GUARDIAN AND HAVE ANSWERED THE PATIENTS/GUARDIANS QUESTIONS TO THE BEST OF MY KNOWLEDGE. I BELIEVE THE PATIENT/GUARDIAN HAS BEEN ADEQUATELY INFORMED AND HAS VOLUNTARILY CONSENTED.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Physician's Signature: \_\_\_\_\_