Saint Francis GI Endoscopy, LLC

COLONOSCOPY

INFORMED CONSENT TO DIAGNOSTIC OR THERAPEUTIC PROCEDURES, AND RENDERING OF OTHER MEDICAL SERVICES

I authorize my physician and his/her assistants selected by him/her, to administer sedation and to perform the following procedure and/or diagnostic procedure: **Colonoscopy with Polypectomy and or Biopsy if indicated.**

Colonoscopy – Examination of the large intestine with a flexible tube passed through the anus. The entire large intestine is usually examined. The lower small intestine may be examined.
Biopsy – The removal of small pieces of tissue for analysis.
Polypectomy – Removal of small growths from the intestinal tract with special instruments
Sedation and Analgesia – The administration of medication into a vein, under the physician's direction, prior to and during the procedure, to make the procedure tolerable by relieving anxiety, discomfort, or pain. The medications may cause temporary forgetfulness so you may not remember what happens during the procedure or for a time afterwards.

Alternatives - X-Ray tests ("lower GI series" or barium enema") or surgery are sometimes recommended as alternatives. X-Rays are less likely to cause a complication but are less accurate for diagnosing important conditions, and do not allow treatment such as removal of growths (polyps) or biopsy. Surgery is more likely to cause a complication, and is often not necessary. No test at all is an option, but no testing carries risks of failure to diagnose or prevent serious disease. It is possible to perform this test without anesthesia/sedation.

Risks - Colonoscopy involves some risks. Major complications include perforation and bleeding. Complications may occur even when a procedure is properly performed. Treatment of these conditions may require surgery. This is a highly accurate procedure, but with any test there is a small chance of missing something. Administration of sedation and analgesia involves a risk of heart or lung problems, needle site irritation, and sleepiness. All these complications are possible but occur with low frequency. Your physician will discuss this frequency with you, if you wish, with particular reference to your own indications for Colonoscopy.

Consent for Administration of Anesthesia/Sedation - My physician has reviewed the risks of sedation with me. I accept these risks and consent to the administration of sedation. No guarantee has been made as to the results thereof. I have arranged to have a responsible person drive me home. I understand that impairment of full mental alertness may persist for several hours following the administration of anesthesia sedation, and I will avoid making decisions or taking part in activities, which depend on full concentration or judgment during that period.

(reverse side, please)

Consent to Resuscitation - I understand that even though the physicians and staff of Saint Francis GI endoscopy, LLC. respect my right to participate in decisions regarding my health care, the policy of Saint Francis GI Endoscopy, LLC is that all patients undergoing procedures will be considered eligible for life sustaining emergency treatments. The signed consent implies permission for resuscitation and transfer to a higher level of care.

Consent for Transfer/Disposal -I authorize the pathologist to use his/her discretion in the disposal of any tissue or growths removed during the procedure described.

Consent for Photography - I consent to photography of the procedure for medical, scientific, or educational purposes, provided my identity is not revealed by the pictures or descriptive text accompanying them.

Discharge Instructions - The discharge instructions have been reviewed with me and I understand them. I will receive a copy to take home with me when I am discharged.

PATIENT: I have had sufficient opportunity to discuss my condition and treatment with my physician. All of my questions have been answered to my satisfaction.

PHYSICIAN: I have informed the patient, answered their questions and obtained consent for the procedure listed above.

<Signature Doctor> <Signature Patient>

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INSTRUCTIONS FOR AFTER COLONOSCOPY

1. You will be able to resume your usual diet today. We will offer you something to eat and drink before you leave.
2. Do not drive, drink alcohol, operate machinery, make critical decisions, or do activities that require coordination or balance for the remainder of the day.
3. Rest at home today. Light activity is permitted. Resume all your usual activities tomorrow. The medications you received may cause temporary forgetfulness so you may not remember what happens during the procedure or for a time afterwards.
4. Because air was put into your colon during the procedure, expelling large amounts of air through your rectum is normal. If you experience the discomfort of "gas" lie on your left side with a heating pad or hot water bottle on your stomach to relieve it.
5. You may not have a normal bowel movement for 1-3 days because of the prep, Some people experience loose stools initially, some return to their normal routine and some people do not have a bowel movement for 3 days. This is not considered abnormal.
6. **YOU MAY RESUME YOUR USUAL MEDICATIONS.** If we want you to refrain from taking aspirin, ibuprofen, Plavix, Coumadin, etc., it will be indicated here. We will also tell you when you can resume these medications. **IT IS OKAY TO TAKE TYLENOL.**
7. Call your doctor's office in 1 week for lab results if biopsies were taken or polyp(s) were removed.

CALL YOUR DOCTOR AT ANY TIME IF YOU EXPERIENCE ANY OF THE FOLLOWING:

A. **Chills and/or fever over 100 degrees by mouth**
B. **Persistent nausea or vomiting**
C. **Severe abdominal pain that lasts longer than a day**
D. **Pain, redness or swelling at the site where your IV was placed that is not improving with warm compresses applied (4) four times a day for (2) two days**
E. **Black, tarry stools**
F. **Any rectal bleeding – exceeding one tablespoon. Spots of blood are OK**
G. **Chest pain is not associated with this procedure. If you are having chest pain, treat it like a heart problem and seek immediate medical attention. Call 9ll**

If you have any questions on the above instructions call us at (860)683-9991, ext. 106 Monday through Friday 7:00AM – 4:00PM and ask for an Endoscopy nurse. If we are not in, please call your physician.

PATIENT: I have been verbally instructed in the discharge care and understand these instructions. I have been told I will receive a copy of these instructions along with the findings of the examination when I am discharged.

NURSE/TECH: I have reviewed the above instructions with the patient. He/she demonstrates satisfactory understand of them.

<Signature Nurse> <Signature Patient>

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INFORMED CONSENT FOR ADMINISTRATION OF ANESTHESIA/SEDATION

Anesthesia is a specialty medical service which manages patients who are rendered unconscious or with diminished response to pain and stress during the course of a procedure. I understand that it will be necessary to be placed under anesthesia in order to perform the above described procedure, and I consent to the use of anesthesia as deemed necessary and appropriate by my anesthesia care provider or by my physician. Anesthesia involves risks in addition to the risks of the procedure itself. These risks include but are not limited to, adverse drug reactions, brain damage, death, nerve injury, damages to teeth or dental work, damage to vocal cords, respiratory problems, minor pain and discomfort, damage to arteries or veins, headaches, backache or worsening pre-existing disease(s). The purpose, necessity, and risk of anesthesia have been explained to me by an anesthesia care provider or by my physician and there has been sufficient opportunity to discuss the proposed treatment and associated risks. During the course of the procedure, conditions may require additional or different anesthetic monitoring or techniques, and I ask that the anesthesia care provider provide any other necessary services for my benefit and well-being. I agree to anesthesia for my procedure as communicated to me by my anesthesia care provider or by my physician.

TYPES OF ANESTHESIA AND DEFINITIONS:

GENERAL ANESTHESIA – Include but not limited to, loss of airway reflexes. Patient may require artificial airway such as Laryngeal Mask Airway (LMA) that is inserted inside the mouth and covers the larynx (windpipe opening), oropharyngeal airway, nasal airway, and/or endotracheal tube. Supplemental oxygen will be administered.

MONITORED ANESTHESIA CARE (MAC) – Includes the monitoring of at least blood pressure, oxygenation, pulse and mental state, supplementing sedation and analgesia as needed. Supplemental oxygen will be administered.

CONSCIOUS SEDATION – Sedation administered and monitored by a registered nurse under the direction of the credentialed licensed independent practitioner. This plan of care includes continual monitoring of blood pressure, oxygenation, pulse, rate/rhythm, level of consciousness, and pain level until the patient's consciousness has returned to approved/accepted levels of consciousness. Supplemental oxygen will be administered.

RISKS AND COMPLICATIONS – May include but are not limited to minor pain and discomfort, muscle aches, backache, nerve injury, sore throat, localized swelling and/or redness, nausea, damage to vocal cords, allergic/adverse reaction, aspiration, pneumonia, damage to teeth or dental work, headache, inability to reverse the effects of anesthesia, ophthalmic (eye) injury, paralysis, recall of sound/noise/speech by others, seizures, brain damage, coma and death.

I have been given the opportunity to ask questions about my anesthesia and feel that I have sufficient information to give this informed consent. I agree to the administration of the anesthesia prescribed for me.

I DECLARE AND REPRESENT THAT I HAVE READ THE ABOVE AND UNDERSTAND IT IS TRUE.
No guarantee or warranty has been made to the result of the anesthetic procedures.

<Signature Anesthesiologist> <Signature Patient>