ARIZONA DIGESTIVE INSTITUTE

INFORMED CONSENT for GASTROINTESTINAL (GI) PROCEDURE

COLONOSCOPY

1. I, _____ authorize and direct my physician: _____ and/or the associates and assistants of his/her choice to perform the following procedure(s): **Colonoscopy with possible biopsy and/or polypectomy and possible Dilation** and/or to perform any other therapeutic procedure that in her/his judgment may dictate to be advisable for my wellbeing.
2. I confirm the following: that my physician has explained to me the nature, purpose, and possible consequences for the procedure as well as benefits and risks involved, possible complications, (such as, but not limited to, phlebitis, bleeding, perforation, allergic reactions, irregular heart rhythm, aspiration, and dental/oral injury) and all other possible complications incident to other diseases I may have. Possible alternative methods of treatment have been discussed. I understand that there are no guarantees concerning the outcome of my procedure and that I will have the opportunity to discuss the issues noted above with my physician and have my questions answered.
3. I hereby authorize and direct the above named physician and/or associates, assistants or consultants to provide such additional services for me as they deem reasonable and necessary, including but not limited to the administration and maintenance of anesthesia, or sedation/analgesia and the performance of services involving pathology, radiology, and the presence of a medical product representative, and I hereby consent thereto.
4. I consent to the photography during the procedure to be performed including the appropriate portions of the body, for medical, scientific, or educational purposes, provided that my identity is not revealed by the pictures or by the descriptive texts accompanying them.
5. By my signature below, I authorize the pathologist to use his discretion in the disposal of any severed tissue removed from my person during the procedure set forth above.
6. In the event an employee or physician is accidently exposed to blood borne pathogens, I give permission to have my blood tested for HIV and Hepatitis B&C Virus.
7. I acknowledge that I am not to operate a motor vehicle, consume alcoholic beverages, or sign any legal documents until tomorrow.
8. If an emergency should arise, calling for additional procedures, operations, or medications, I authorize my physician and his/her associates to do what they deem advisable in my best interest. I authorize the transfer to a hospital for in-patient care after my physician has explained the risks and benefits to me or my designated other.

Patient Signature_____

Witness Signature_____

Physician's Statement: I certify that I have informed _____ of the following: The nature, purpose, and possible consequences of the procedure, benefits and risks involved, possibilities of complications, and possible alternative methods of treatment.

Physician Signature_____