SAND LAKE
SURGERY CENTER

7477 Sand Lake Commons Boulevard
Orlando, Florida 32819

COLONOSCOPY CONSENT FORM

Under Florida law, you have both the right and the responsibility to make decisions concerning healthcare. The physician shall provide you with the necessary information, but, as a member of the healthcare team, it is essential that you enter into the decision-making process. This form has been designed to document your informed consent to the invasive procedure(s) that you have discussed with your physician.

Authorization and Nature of Procedure(s): I request and hereby authorize:

Dr. ______________________________ and/or associates to perform a procedure(s) known as a colonoscopy, possible biopsy, possible polypectomy or ablation of tumor and possible cautery or injection to control bleeding. Proper preparation is important for this examination since the colon must be very clean in order to see well. I have been given instructions when to stop eating and drinking. I understand completion of these instructions will directly affect the safety and accuracy of this test. I understand this procedure(s) is done by inserting a long, flexible instrument into the rectum to examine the large intestine. Biopsies (small pieces of tissue) may be taken if abnormalities are found or suspected. If a polyp is found, it may be removed by using electrocautery or other ablation techniques. I understand that occasionally a polyp is too large or of such shape that it is not possible to remove the polyp at the time of the colonoscopy and that an abdominal operation may be required. Before insertion of the instrument, I will be given sedation intravenously. If tissue is recovered, it may be examined by a Pathologist.

Risks and Complications: I understand that there are risks and possible complications involved with colonoscopy Intravenous sedation reactions including allergic reactions, slowing of breathing or decreased blood pressure; perforation of the colon; bleeding from the colon including after removal of polyp; and that there are other rare complications including abnormality of heartbeat and rupture of abdominal organs. Death and permanent disability have been reported after colonoscopy.

I acknowledge and understand that complication from the procedure(s) may result in the need for further surgical intervention.

I acknowledge and understand that because no two human beings are alike, the potential risks and complications may vary from person to person. For that reason, I understand the prediction of complications and risks cannot be accurately made.

I understand that unusual complications, not normally expected and beyond those mentioned above, can occur during this procedure(s), but that such complications are so infrequent that they are not usually explained to patients. I do not wish to have any further explanation given to me, even though I have been advised that I am entitled to such further explanation, if I so desire.

No Guarantee or Assurance: I understand that, because differences exist between human beings, both in their anatomy and in terms of their response to treatments, my doctor cannot give me any guarantees as to the outcome of this procedure(s) or whether or not I will encounter any risks or complications, whether known or unknown, associated with this procedure(s).

Additionally, because no test is 100% capable of locating lesions, I understand that this test has a definite rate of missing abnormalities, albeit small. Recognizing that there is a possibility of a failure to diagnose, further testing may be warranted at some time and I must report any persistent or unusual symptoms to my physician to better guide in the detection of lesions that conceivably may be missed.

Alternative Treatment/Procedure(s): I understand that there are alternatives to this procedure(s) including x-rays, surgery and no procedure(s). I understand the risk of x-ray is reaction to the contrast which is used, the tube which is used to introduce the contrast and the risk that the x-ray may miss lesions. Surgery, if warranted, has risks of bleeding, infection and damage to the organs and the risk of increased anesthesia required. The choice of no procedure(s) incurs the risk of missed diagnosis and/or worsening of the condition.

Other Operations and/or Procedure(s): I understand that, during the course of this procedure(s), the performance of other operations or procedure(s), in addition to or different from those now contemplated, may become necessary in the medical judgment of the above-named physician and/or his associates. I authorize such physician and/or his associates to perform such other procedure(s) as he/she deems necessary, within the exercise of his/her sound medical judgment.

Attendance of Other Health Care Providers: I understand that physicians, nurses, or other persons in training programs and currently assigned to the facility may observe in this procedure(s), according to the instructions and under the supervision of the physician and/or association named above.

Sedation: Procedural sedation describes the state that allows patients to tolerate procedure(s) while maintaining adequate cardiopulmonary function and the ability to respond purposely to verbal command and/or physical stimulation. The benefits of procedural sedation are the ability to undergo the study without undue anxiety, stress and without compromising the quality of the study. The risks of procedural sedation include drowsiness, dizziness, weakness, nausea, constipation, allergic reaction, temporary loss of short-term memory, hallucinations, a significant increase or decrease in blood pressure, elevated heart rate, hypoxia, respiratory depression, cardiac arrest and possible damage to vital organs or death. If general anesthesia is anticipated, then a separate consent will be initiated for anesthesia.

Tissue Disposition: I authorize the appropriate disposal of any body tissue removed during the course of the above procedure(s) after the same has been examined by the Pathologist.

Advanced Directives: These are not honored at Sand Lake Surgery Center. In the event of an emergency or life-threatening situation, advanced cardiac life support procedures will be instituted in every instance and the patient will be transferred to a higher level of care.

Consent to Transfer: I understand that the procedure to be performed on me at the Facility will be done on an outpatient basis and that the Facility does not provide 24-hour care. If my physician or any other duly qualified physician in his/her absence shall find it necessary or advisable to transfer me from the Facility to a higher level of care, I consent and authorize the employees of the Facility to arrange for and affect the transfer to ______________________________ hospital.

Photographs / Videotapes: I authorize my physician and SAND LAKE SURGERY CENTER to photograph and/or videotape my procedure(s) at the discretion of my physician. I understand that the photograph(s) / videotape will be used only for the purpose of medical study/research, education and/or documentation for my medical record.

Opportunity for Further Information: I understand that other physicians may recommend a different procedure(s) and that I am free to see the advice of other physician(s) as I might choose. Prior to signing this document, I have taken the time to consider whether I wish to ask further questions of my physician or whether I desire a second opinion. I understand that, by signing this document, I have voluntarily agreed to undergo the procedure(s) described above. I understand that my signature indicates that I do not desire any further opinions from other physicians, nor do I wish to ask any further questions.

Opportunity to Read Documents: I acknowledge that prior to signing this document, I have had the opportunity to read this document and that I thoroughly and fully understand it.

Permission for Blood Draw - In the event of an employee or physician sustaining an accidental exposure to blood or other bodily fluids by needlestick, splash or scalpel injury, for example, I consent to have my blood drawn for blood-borne diseases to include, but not limited to, hepatitis and HIV. I understand that my physician will inform me of the test results after being discharged from the facility.

I HAVE HAD SUFFICIENT OPPORTUNITY TO DISCUSS THE MEDICAL CONDITION AND THE PLANNED PROCEDURE(S) AND ANESTHESIA/SEDATION WITH THE ABOVE-NAMED PHYSICIAN AND/OR ASSOCIATES AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I UNDERSTAND BOTH SIDES OF THIS FORM, THE MEDICAL CONDITION AND THE PLANNED PROCEDURE(S) AND I HAVE ADEQUATE INFORMATION UPON WHICH TO BASE AN INFORMED CONSENT. DO NOT SIGN IF YOU HAVE ANY FURTHER QUESTIONS.

☐ I HAVE ADVANCED DIRECTIVES

PATIENT / LEGALLY AUTHORIZED SIGNATURES

______________________ / ______________ ______________________________

Date Time Patient Signature

______________________________ ______________________________

Witness Parent / Legal Guardian (if patient a minor)

______________________________ ______________________________

Witness Signature (signature / phone consent) Translator Language Translated

Patient Unable to sign because: ______________________________

PHYSICIAN DECLARATION

I have explained the contents of this document to the patient and have answered all the patient's questions and, to the best of my knowledge, I feel this patient has been adequately informed and has consented.

______________________________ ______________________________

Physician Signature Date