Patient Label

Green Mountain Surgery Center

I hereby authorize Dr._____ and any of his/her associates/assistants to perform a **Colonoscopy, possible biopsy, possible polypectomy**.

- I understand that this is a procedure performed to examine the inside of my colon, or large intestine. The examination uses a long, flexible, fiberoptic lighted tube that allows for viewing inside of the colon in order to evaluate its health and diagnose conditions affecting your colon.
- I understand that this procedure may not be able to be completed due to poor bowel preparation, bowel disease or other problems.
- I understand that the procedure is generally safe, but certain risks accompany any endoscopic procedure. The risks of a Colonoscopy include but are not limited to the following: bleeding, infection, reaction to the sedation medication, aspiration, pneumonia, intestinal perforation, and injury to the spleen or other abdominal organs. Rarely, surgery may be necessary.
- I understand that the practice of medicine is not an exact science, and that no guarantee can be made regarding the outcome of my planned procedure.
- I acknowledge that the reasonable alternatives of the proposed procedure have been explained to me.
- I understand that a colonoscopy is not completely accurate and occasionally abnormalities including cancers and polyps may be missed.
- The risks, benefits and alternatives of sedation have been explained to me and I consent to sedation. If the nature of the procedure(s) requires an anesthesiologist I consent to the administration of anesthesia to be administered under the direction of a member of the Anesthesiology Department.
- If I receive sedation I understand the importance of avoiding driving and performing activities that might be dangerous to myself and others.
- I authorize my physician and the laboratory to which any specimens will be sent to dispose of any specimens removed as a result of the procedure, or to preserve said specimens at their discretion for scientific or teaching purposes.
- I acknowledge that I have been given the opportunity to ask questions concerning this procedure and that my questions, if any, have been answered to my satisfaction.
- I acknowledge that I have read this document in its entirety, and that I fully understand it.

By signing below, I am agreeing to all of the above, except as follows:

_____

_____ _____

Patient Signature Date **Physician Signature Date**