COLON RECTAL ASSOCIATES OF CENTRAL NEW YORK, LLP

JOHN D. NICHOLSON, MD
MICHAEL A. MOFFA, MD
DAVID A. NESBITT, MD
JAMES R. BERRY, MD

COLONOSCOPY PROCEDURE CONSENT

I, (print name of patient or person authorized to consent)
_____,
hereby authorize my attending physician to perform:

__ Colonoscopy; examination of all or part of the colon, possible biopsy or polypectomy

On me, or_____, my_____.

The following physician(s) is/are expected to be actively involved in the above-described procedure and I hereby consent to their participation:_____.

The endoscopic procedure to be carried out has been fully explained to me and I fully understand the nature and consequences to be expected. I have also been informed there are risks such as loss of blood, infection, cardiac arrhythmia, perforation, etc. that are attendant to the performance of this endoscopic procedure. I understand my attending physician or a registered nurse under the direct supervision of my physician will be administering any sedation or analgesic agent that is necessary. It may also be necessary to administer other forms of medication such as antispasmodics, antibiotics (as indicated), or emergency medications.

Any tissue surgically removed may be disposed of by the hospital in accordance with customary practice. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

CONSCIOUS (MODERATE) SEDATION CONSENT: I have been informed by my attending physician that I may need conscious (moderate) sedation to perform the above stated procedure. I have had the risks, benefits, and available alternatives to conscious (moderate) sedation explained to me by my physician. I have had the opportunity to ask questions concerning the risks, benefits and available alternatives. I hereby consent to conscious sedation.

I HAVE READ THE ABOVE AND UNDERSTAND THE CONTENTS.

Signature of patient or other person authorized to consent *Relationship, if not patient*

_____ _____

Witness to authorized signature

_____

Date_____ Time_____

I have explained to the above patient or authorized party the procedure which I feel is indicated at this time. I have explained the nature, risks and the benefits of the procedure and alternatives available. I have explained the possible need for conscious (moderate) sedation and the risks and benefits associated with this. I have given the patient an opportunity to express any concerns and ask questions regarding the procedure and sedation plan.

*Signature of Physician:*_____*Date:*_____