EXETER HOSPITAL
5 Alumni Drive Exeter, NH 03833 603.778.7311

PATIENT ID OR LABEL

Patient Name:_____DOB:_____

CONSENT FOR OPERATION OR PROCEDURE / SEDATION, IF APPLICABLE

Patient Name: _____ Date of Birth: _____

Procedure: Colonoscopy with Possible Biopsy, Polypectomy and/or Control of Bleeding

Name of Practitioner performing the procedure(s) or important aspects of the procedure:

_____

Name of other practitioners who may perform significant surgical tasks: (include 1st assists if they are performing a substantive portion of the procedure.)

Name: _____
Task: _____

I authorize my Physician/Practitioner and the other practitioners named above to perform the above procedure at Exeter Hospital.

Colonoscopy is a procedure that enables your gastroenterologist to visualize the inner lining of the colon and sometimes the end of the small bowel. The procedure is performed with a long, thin, flexible device with a camera and light called a colonoscope.

The procedure is very important in the detection and evaluation of several diseases and conditions affecting the colon and small bowel. These include polyps in the colon, cancer, bleeding, diarrhea, abdominal pain, diverticulosis, hemorrhoids, and colitis amongst others. If abnormalities are detected biopsies can be obtained. The majority of polyps can be removed via a procedure called polypectomy.

1. I understand that during the course of the procedure, my Physician/Practitioner or assistants may discover a condition that they did not or could not have anticipated which may necessitate the involvement of another practitioner. In that case, I authorize them to perform such additional or different surgical procedures as they think are important to be performed at this time and to involve other practitioners as appropriate for this purpose. I understand that the practice of medicine and surgery is not an exact science, and I agree that no guarantees have been made to me about the results of this procedure. I understand that surgery and procedures have certain risks, including, but not limited to infection, cardiac arrest, possible loss of blood and the need for further surgery.
2. Colonoscopy is generally considered quite safe, however, as with all procedures, there are certain risks. These risks or potential complications include, but are not limited to:
   - Perforation (a tear in the lining) or puncture of the bowel. Although rare, may require surgical correction.
   - Bleeding (for up to 2 1/2 weeks after polypectomy). Significant bleeding may require transfusion. A repeat colonoscopy or surgery is sometimes necessary to stop bleeding.
   - Electrolyte abnormalities, dehydration and fluid overload from the preparation have been reported to cause cardiac arrhythmias, kidney dysfunction, and rarely death.
   - There are a few published reports of other extremely rare complications including pancreatitis and injury to the spleen.
   - Although colonoscopy is considered the "gold standard" for colon cancer screening, it is not a perfect procedure. There is a 5-15% chance that a polyp could be missed and turn into a cancer.
3. I agree to the administration of blood and/or blood products such as, but not limited to, packed red cells, platelets, frozen plasma or cryo, during or within 5 days of my procedure if it becomes necessary to prevent, stop bleeding or replace lost blood volumes. My physician/practitioner has explained the benefits to be expected as well as the risks. The principal risks are described below:
   A. Transmission of an infectious disease.
   B. Bacterial contamination of the blood products.

C. Non-infectious transfusion risks and adverse consequences include, but are not limited to, transfusion reactions, developing antibodies against the donor's antigens, some physical effects such as, cooling of my body, or too much fluid and/or chemical effects such as too little or too much calcium or iron in my blood.

D. Immunologic Effects, such as, Transfusion-related acute lung injury (TRALI) and Transfusion-related Immune Modulation (TRIM):
TRALI is a rare but devastating complication of blood therapy. Clinically, symptoms are similar to that of adult respiratory distress syndrome, consisting of hypotension (low blood pressure), fever, dyspnea (difficulty breathing), and tachycardia (rapid heartbeat). The onset typically occurs within 6 hours of transfusion, but most cases present within 1 or 2 hours. Transfusions of all blood products have been associated with the disease.
TRIM causes relative immune suppression, thereby potentially increasing risk of infectious complications such as pneumonia, sepsis and surgical site infection. It has been associated with transfusion of cellular blood components such as red blood cells and platelets.

4. For procedures that do not require General Anesthesia, I agree to the use of certain types of sedation (drugs to make me more comfortable during the procedure) either intravenously or otherwise. I understand that there are certain risks of receiving sedation, including, but not limited to: awareness of the procedure and discomfort, injury to mouth or teeth, adverse reaction to medication, neurological complications, breathing problems, cardiovascular abnormalities, cardiac arrest or death. I have also been told about the option of not receiving sedation.
5. I authorize my Physician/Practitioner or Pathologist/designee, who are independent contractors, to examine any tissues, organs, other body parts, or foreign bodies that may be removed during the operation or biopsy performed on me. I further authorize my Physician/Practitioner, Pathologist/designee who are independent contractors, or such pathologists to retain, preserve, and use for scientific, educational, or research purposes any tissue or specimen, while keeping my identity confidential, or to dispose of these items in accordance with Hospital policies.
6. I understand that there may be Healthcare Industry Representatives or other people present if medically necessary for performance of the procedure or for purposes of medical education, training and equipment management.
7. I agree to have images taken during my treatment for medical documentation and medical education purposes. If images are used for medical education, my identity will be kept confidential.
8. If I am receiving an implantable medical device that is required to be tracked under the Safe Medical Devices Act, I authorize the hospital to release to the manufacturer, my name, address, social security number and my physician/practitioner's name and any other information required by law to be reported. I understand that this information will be used to help locate me if, in the future, the manufacturer needs to contact me with regard to the medical device.

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I have had the procedure/sedation explained to me, including the anticipated benefits, material risks, alternative therapies and the consequences of declining the recommended or alternative therapies based on available clinical evidence. I have had an opportunity to ask questions and have had them answered to my satisfaction.

Date and Time _____ Signature of Patient or ***(Check One)***

☐ Parent (if minor patient) or ☐ Invoked Durable Power of Attorney for Healthcare or
☐ Legal Guardian or ☐ Surrogate or ☐ Appropriate Consenting Party

If not signed by patient, state reason: ☐ temporary incapacity ☐ permanent incapacity

Telephone / Verbal Consent: ☐ Yes Reason: _____

Professional witness to above signature: _____ Date and Time _____ Witness Printed Name _____ Witness Signature
(Signed when Physician / Practitioner and patient do not sign this document together.)

I have explained to the patient (or the person legally authorized to consent for the patient) the procedure/sedation, including the anticipated benefits, material risks, alternative therapies and the consequences of declining the recommended or alternative therapies based on available clinical evidence.

Date and Time _____ Signature of Physician / Practitioner

COMPLETE THIS WHEN APPLICABLE:
I request to have the current Do Not Attempt Resuscitate (DNAR) status suspended during this procedure and until I recover from the effects of anesthesia: ***(Check One)*** ☐ Yes ☐ No

I request to continue the current DNAR status for this procedure: ***(Check One)*** ☐ Yes ☐ No

Upon request, Palliative Care consult is available.

Date and Time _____ Signature of Patient _____ Date and Time _____ Signature of Physician/Practitioner

EXPIRATION: This consent is valid and effective as it pertains to this episode of care.