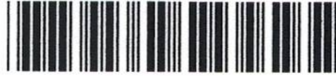
- ☐ CROZER
- ☐ DCMH
- ☐ COMMUNITY HOSPITAL
- ☐ SPRINGFIELD HOSPITAL
- ☐ TAYLOR HOSPITAL
- ☐ BRINTON LAKE
- ☐ HAVERFORD



CO0010

CONSENT TO DIAGNOSTIC OR INTERVENTIONAL PROCEDURE(S) OR TREATMENT

Patient Label

1. I consent to Dr. BOYD / PARIKH / SHIH, or his or her associate, to perform upon me the following procedure and/or medical treatment

   COLONOSCOPY UNDER CONSCIOUS SEDATION, POSSIBLE BIOPSY AND/OR POLYPECTOMY

   CIRCLE: LATERALITY (SIDE): Right Left Not Applicable

2. I agree that the following information about the above and procedure and/or treatment have been explained to me:
   - The reason for, nature and extent of the procedure and/or treatment.
   - Other types of procedures and treatment I could choose, and what may happen if I choose that procedure and/or treatment or if I do not have any treatment.
   - Possible complications include, but are not limited to: infection, bleeding, nerve injury from positioning or the procedure, injury or perforation of other internal organs, heart and lung damage, including cardiac arrest and death.
   - Burns are very rare but can occur from cardio-version, electrocautery or radiation.
   - Other risks and the complications can also include, but are not limited to:

     BLEEDING, IMMIDIATE OR DELAYED

     INJURY TO THE COLON WHICH MAY REQUIRE SURGERY TO REPAIR

     RECURRENCE OR INCOMPLETE REMOVAL OF POLYPS

     NAUSEA, ABDOMINAL DISCOMFORT, DISTENTION (TEMPORARY)

3. This information was provided to me in terms that I understand. I am aware that the practice of medicine is not an exact science. I agree that no guarantee of results, success or cure has been given to me.

4. If, in the opinion of my doctor, any conditions are found in the course of performing the treatment described above which require additional or different treatment than those listed above, I allow my doctor to perform such procedures.

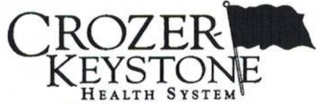
5. I understand that my doctor (see paragraph 1), may need to administer moderate sedation, local anesthesia and/or a nerve block. The possible complications of the type of the planned anesthesia have been explained to me. A separate consent will be obtained for anesthesia if administered by an Anesthesiologist.

6. I consent to the taking and publication of any photographs and taping in the course of this treatment for inclusion in my medical record, for treatment purposes or for education purposes (without identifying me by name or other means).

7. I give up all rights, financial or otherwise for any images taken and/or for any tissues, organs, or medical devices removed.

8. I consent that approved personnel may observe my treatment, and/or procedure, including students, technical sales representatives, or others with the consent of my doctor.

9. I consent to the release of my Social Security number to the manufacturer of any implants or devices, as required by law.



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Patient Label

10. I understand that I can change my mind any time before this procedure and withdraw my consent in whole or in part.

11. I understand that my doctor and those doctors that care for me in the hospital may not be employees or agents of the hospital. I will receive a separate bill for their services.

12. I certify that I read this consent form or it has been read to me. I understand the information in this form, and all my questions were answered to my satisfaction.

Time	**Date**	**Signature of Patient/Authorized Representative and Relationship**

☐ Patient unable to sign or verbal consent obtained on the phone.

Time	**Date**	**Signature of witness (necessary when the patient is unable to sign this document; when telephone consent is obtained, or when the patient's signature is obtained by someone other than the physician).**

I have explained the nature of the above treatment as well as reasonable anticipated risks, complications, and alternatives to such treatment.

Time	**Date**	**Physician**

Valid for 90 Days.
If you would like a copy of this form, please ask your doctor.