CHAMBERSBURG ENDOSCOPY CENTER, LLC
835 Fifth Avenue, Chambersburg, PA 17201

Consent for Colonoscopy
(*Do **not** sign without reading*)

Name: _____ Date: _____ Time: _____ A.M. P.M.

_____ will be performing a colonoscopy under sedation/analgesia and/or
Name of Physician
total IV anesthesia with performance of polyp removal, biopsies, and/or treatment of bleeding source if indicated

____ Yes It has been explained to me how the procedure will be done and what to expect.

____ Yes It has been explained why this procedure was recommended to me.

____ Yes It has been explained the available alternatives and choices to this procedure, as well as the risks of not having the procedure done. These include but are not limited to: Alternatives: Barium enema, sigmoidoscopy. Risks of not proceeding with this study include failure to diagnose cause for symptoms. I have been fully informed in general terms of the risks, benefits, and alternatives associated with having the procedure at Chambersburg Endoscopy Center instead of a hospital.

____ Yes I have been provided an explanation of the known and recognized risks to this procedure. Specific risks include but are not limited to: risk of aspiration pneumonia, bleeding and perforation (uncommon), splenic injury, heart attack, stroke, breathing difficulties, or medication reaction (rare complications). I understand that my physician will do a careful examination, but it is possible for lesions to be hidden by folds or retained stool and lesions to be missed in the colon.

____ Yes I have had an opportunity to ask questions.

____ Yes I have had my questions answered and I believe I have all the information I need to fully agree to this procedure.

____ Yes I have read and understand this form and truthfully answered all questions.

____ Yes I consent to the procedure.

____ Yes Patient Self-Determination Act of 1990/Advance Directives: Chambersburg Endoscopy Center has made available to me written information on my rights and responsibilities to make health care treatment decisions in compliance with the Patient Self-Determination Act of 1990. I also understand that I am consenting to have an elective procedure performed upon me at this facility. If I have an Advance Directive and an untoward event occurs, Chambersburg Endoscopy Center will stabilize and transfer me to Chambersburg Hospital.

____ Yes Personal Valuables: Chambersburg Endoscopy Center provides facilities for the safekeeping of any valuables and any valuables kept by the patient are kept at the patient's risk. I hereby accept full responsibility for any personal effects taken to the procedure room, including such things as dentures, eyeglasses, contact lenses, hearing aids.

_____ _____
Signature of patient or person authorized to consent for patient Signature of Witness

I certify that the patient/parent/guardian or other legally responsible person has been provided information on the risks and hazards, Benefits and alternatives to treatments outlined above, had questions within my area of expertise answered and has given consent.

_____/_____/_____ _____ _____
Date Time Signature of Physician