GASTROENTEROLOGY ASSOCIATES OF NORTHERN VIRGINIA
WILLIAMS DRIVE ENDOSCOPY CENTER

Colonoscopy Information/Consent Form

Colonoscopy is an examination of the colon with a fiberoptic endoscope. This involves the insertion of a flexible instrument into the rectum and then further to evaluate the entire colon.

Colonoscopy may be only diagnostic (looking at the colon alone and/or possibly obtaining a tissue biopsy) or it may be therapeutic (a polyp may be removed or a bleeding site cauterized using an electrocautery device)

SEDATION: Sedation is generally necessary and is provided intravenously to insure your relaxation and comfort
RISK: As with any medical treatment, colonoscopy carries certain risks. The risks of colonoscopy – which include bleeding and perforation are relatively small and depend on whether the examination is diagnostic or therapeutic.

Risks of colonoscopy	Diagnostic	Therapeutic
Bleeding	less than 1%	1.5 – 2%
Perforation	less than 1%	less than 1%
Reaction to Sedation	less than 1%	less than 1%
Missed lesions	about 5%	about 5%

Certain medical situations may be associated with greater risks, and your doctor will discuss these with you. Other risks include drug reactions from the medications used for sedation and possible vein irritation or pain at the site of the injected medicine. Other unanticipated complications may occur.

There are alternative diagnostic and/or therapeutic approaches including x-ray and surgery which have been discussed. I have read the above information and understand the indication for, and risks of, this examination. I hereby authorize and permit ______________________ MD, and whomever he/she may designate as his/her assist(s), to perform a colonoscopy on me. I consent to the taking and reproduction of any photographs of the procedure for professional purposes.

Furthermore, if any unforeseen conditions arise during this procedure requiring additional procedures, operations, or medication (including anesthesia), I request and authorize the physician performing the procedure to do whatever he/she deems advisable in my best interests.

Patients name _________________________________ date_______________

Signature _____________________________________

M.D. signature _________________________________