Request And Authorization For Colonoscopy, Biopsy And Polypectomy: MIM #182

I request and authorize Dr. ___________________ and/or associates or assistants of his/her choice at The University of North Carolina Hospitals to perform a colonoscopy and biopsies, on ______________________________.

Patient’s Name

Authorization is also given for control of bleeding, removal of abnormal growths, and dilation of abnormal areas of narrowing of the gastrointestinal tract.

Description of the Procedure:
The colonoscopy will involve the insertion of a long, flexible, video instrument called a colonoscope into the rectum. By pushing on the colonoscope, the doctor can usually advance the tip of the scope through the entire large intestine, which is about 4 feet long. The colonoscope will allow doctors to view the lining of the large intestine, or colon.

If any abnormalities are seen, a biopsy may be performed. A biopsy involves the removal of one or more small samples of the intestine, through the colonoscope, to be examined by a pathologist. If a growth or polyp is discovered, the doctor may remove it, if they feel it can be done safely.

Treatments may be performed if a source of bleeding, or a narrowing of the digestive tract is found. These procedures may include injection of medications into the bleeding site and/or treatment of the bleeding site with an electrical heating device. Narrowed areas of the gastrointestinal tract may be enlarged with the use of balloons or other devices.

Sedatives (such as midazolam, fentanyl, droperidol and/or morphine) may be used through an intravenous line, to cause relaxation and drowsiness. These medications also may cause a brief period of memory loss and result in not having a recollection of the procedure. Many patients sleep through the procedure, which can last from 10 to 90 minutes.
The following risks are associated with a colonoscopy:

**Slowing of breathing and abnormal heart rhythms:** Intravenous medications may cause a slowing of breathing, and in rare cases may cause breathing to stop. They also may cause lowering of blood pressure and/or abnormal heart rhythms. I will be carefully monitored for changes in my breathing, blood pressure and heart rhythms during and after the colonoscopy.

**Perforation of the colon:** A perforation or tear in the wall of the colon occurs in up to 4 per 1,000 colonoscopies. If a polyp is removed during the procedure, the risk of a perforation is 10 per 1,000 procedures. Perforations are treated with antibiotics and/or surgery, which could require a colostomy.

**Bleeding:** Bleeding may develop after a biopsy or removal of a growth. This may occur immediately, or up to two weeks after the procedure. If a polyp is removed during the procedure, the risk of bleeding is 25 per 1,000 colonoscopies. Major bleeding may require treatment with a blood transfusion, repeat colonoscopy, or surgery.

**Infection:** Patients with certain types of heart murmurs or artificial heart valves may request antibiotics before colonoscopy, to reduce the risk of infection of the heart valves.

**Other possible complications:** Patients may rarely experience an adverse drug reaction, bruising or infection at an intravenous site, or injury to internal organs. Other serious complications may rarely occur.

**Death:** Death as a complication of colonoscopy is extremely rare. Reported rates range from zero to 3 deaths per 10,000 colonoscopies.

**Missed abnormalities:** Some growths and even some cancers are not seen during colonoscopy. This may occur if the colon is not completely clean, if there are blind areas in the colon, or if the exam cannot be completed. Inability to complete the exam occurs in fewer than 5 per 100 colonoscopies.

The following benefits are associated with a colonoscopy:
The purpose of a colonoscopy is to gain information about the large intestine that may not be obtained by x-ray or by other diagnostic means, and to treat certain conditions. The procedure is generally very safe and is well tolerated by most patients.

**Alternative options:**
X-rays and surgery are the usual alternatives to a colonoscopy.
Statement of Voluntary Participation:
I have read the information contained in this form, and have had sufficient opportunity to discuss my medical condition and treatment with the undersigned physician. All of my questions have been answered to my satisfaction, and I believe that I have been given adequate information upon which to base an informed consent for a colonoscopy, biopsy, and other possible therapeutic procedures.

I am consenting to having a colonoscopy, biopsy, and other possible therapeutic procedures performed. I understand that I can withdraw my consent at any time. My consent for this procedure is voluntary.

I understand that during the course of the colonoscopy, something unexpected may arise which may necessitate procedures in addition to or different from those described above. If such unexpected circumstances arise, I further request and authorize the performance of additional operations or procedures that may be considered necessary or advisable by the undersigned physician and/or his/her associates or assistants.

I further request the administration of such anesthetics as may be considered necessary, desirable, or advisable by the physician responsible for such service.

I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made concerning the performance, results or interpretation of the colonoscopy.

For the purpose of advancing medical education, I give my permission for observers to be admitted to the operating room or procedure room, and UNC Hospitals and the UNC School of Medicine staff to make and use any photographic or other illustrations of me for diagnostic, scientific, educational, or research purposes, provided that my identity is not revealed. I further authorize UNC Hospitals and the UNC School of Medicine staff to examine and dispose of any tissues or parts that may be removed and to use them for teaching, educational, or research purposes, provided that my identity is not revealed.

Concerns about my colonoscopy that were discussed before the procedure include:
___________________________________________________________________
___________________________________________________________________

I confirm that I have read and fully understand this form, or that it was read to me and I fully understand it, and that all blank spaces were filled in and all inapplicable paragraphs, if any, were stricken before I signed below.

_____________________________________________ ___________________
Signature of Patient/Person Authorized to Sign for Patient Date
____________________________________________ __________________________
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<tr>
<th>Printed Name, Relationship to Patient</th>
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Physician Certification:

I hereby certify that the patient has read, or has had read to him/her, this form and that I have explained the nature, purpose, usual and most frequent risks, benefits, and alternatives to the proposed colonoscopy, biopsy, and other possible therapeutic procedures. I have offered to answer questions and have fully answered any questions by the patient about the procedure. To my knowledge, the patient understands this form and what I have explained to him/her and has consented to the proposed colonoscopy, biopsy, and other possible therapeutic procedures.

Physician Signature  ________________________________  Physician Name

Date:  ________________________________

Witness Certification:

I hereby certify that the patient has acknowledged to me that s/he has requested a colonoscopy, biopsy, and other possible therapeutic procedures, has received an explanation of the nature, purpose, benefits, usual and frequent risks and hazards of and alternatives to the procedure, has had all of his/her questions answered, has fully understood what was explained to him/her, has given his/her consent, and has signed the form above.

Witness Signature  ________________________________  Witness Name

Date:  ________________________________