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Colonoscopy Patient Consent Form

Patient Information:

- **Full Name:** _____
- **Date of Birth:** _____

I, the undersigned, consent to undergo a colonoscopy. This procedure involves the insertion of a long flexible tube into the rectum and through the colon to examine the lining of the large intestine. It may include the removal of polyps or biopsy samples for further examination. The procedure is generally carried out with me lying on my left side but occasionally position change may be needed to complete the procedure. The procedure generally takes 20 minutes but I understand that I will be in hospital for about 4 hours, although delays may occur due to unplanned emergencies or unforeseen circumstances.

I understand that the risks of a colonoscopy may include, but are not limited to: bleeding (approx. 0.5%), perforation of the colon (approx. 0.1%), injury to the spleen, adverse reactions to sedation, infection, aspiration (approx. 0.5%), missed lesions and an incomplete procedure requiring additional investigation. If these uncommon risks occur then hospitalisation, repeat procedures, blood products and/or surgery may be required. I understand that these may carry additional risks which will be discussed with me at that time.

I understand the benefits of a colonoscopy include detection and removal of polyps (which could otherwise turn into cancer), diagnosis of conditions such as inflammatory bowel disease, screening for colorectal cancer, investigation of symptoms such as abdominal pain, rectal bleeding, or changes in bowel habits. I understand that, generally, the benefits of a colonoscopy are significantly higher than the risks.

I have received and understand the instructions for preparing for the colonoscopy. I understand that a good bowel preparation is essential for a good procedure and decreasing the risk of missed lesions and other complications. I understand that colonoscopy remains the best way of accurately identifying abnormalities of the large bowel. I have also received instructions about how to manage any blood thinners or medications for diabetes and weight loss around the time of the procedure. I have also received fasting instructions for the day of the procedure and that I am not allowed to have anything by mouth for 3 hours prior to the procedure.

I understand that sedation will be used for the procedure and that I should not drive, operate machinery or make important decisions until the following day. I understand that I must be discharged into the care of a responsible adult following the procedure.

I understand that my doctor will be available to answer any further questions I may have at the time of the procedure. I understand the information provided and voluntarily consent to proceed with the colonoscopy. I consent to any necessary treatment or interventions that may arise during the procedure, such as the removal of polyps and taking biopsies from the bowel.

Signatures:

Patient Signature: _____ **Date:** _____

Doctor Signature: _____**Date:** _____