VIRTUAL COLONOSCOPY

Virtual colonoscopy is a method for examining the colon and is especially useful as a noninvasive tool to detect colorectal cancer.

Patient's Initials

_____ The details of the procedure including the anticipated benefits and material risks have been explained to me in terms I understand.

_____ Alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me.

_____ I understand that a full colonoscopy bowel preparation will be required.

_____ I understand that the procedure involves room air or CO_2 inflation of the colon so that images may be made.

____ I understand that no sedation or anesthesia will be required.

_____ I understand that a smooth muscle relaxant may be administered via IV.

_____ I understand and accept that the most likely material risks and complications of virtual colonscopy have been discussed with me and may include but are not limited to:

- *bruising/infection at site of IV*
- *incomplete/inadequate visualization of the colon*
- *need for repeat/additional procedure for diagnosis*
- *perforation of colon*

_____ I have informed the doctor of all my known allergies.

_____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.

_____ I have been advised whether I should avoid taking any or all of these medications on the day prior to the procedure.

_____ I am aware and accept that no guarantees about the results of the procedure have been made.

______ I have been advised of the probable consequences of declining recommended or alternative therapies.

_____ I have been informed of what to expect postoperatively, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.

_____ The doctor has answered all of my questions regarding this procedure.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct ____________________, M.D., with associates or assistants of his or her choice, to perform a virtual colonoscopy on ____________________________ (*patient name*) at________________________ (*name of facility*).

I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

____
Patient or Legal Representative Signature/Date/Time

____
Relationship to Patient

____
Print Patient or Legal Representative Name

____
Witness Signature/Date/Time

Continued

7/01
Revised 9/05, 12/05, 1/06, 6/07

This form is for reference purposes only. It is a general guideline and not a statement of standard of care and should be edited and amended to reflect policy requirements of your practice site(s), CMS and Joint Commission requirements, if applicable, and legal requirements of your individual state(s).

SAMPLE

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the *patient/legal representative* *(circle one)* fully understands what I have explained.

____
Physician Signature/Date/Time

_______ copy given to patient
initial

_______ original placed in chart
initial

SAMPLE