This form is provided as a courtesy and should not be construed as legal advice.

PATIENT INFORMED CONSENT

1. OPERATION OR PROCEDURE AND ALTERNATIVES:

I, _____, (patient or guardian) authorize **Doctor Schron / Bracher / Amin / S Patel/ Y Patel**, associates and assistants of his or her choosing to perform the following operation or other procedure:
Flexible sigmoidoscopy with possible biopsy. _____
I understand the reason for the procedure is: **1) Colon cancer screening (see addendum); or 2) Other**
_____
Alternatives include: **Barium enema, colonoscopy .**

2. RISKS: This authorization is given with the understanding that any operation or procedure involves some risks and hazards. Some of the significant risks of this particular procedure are:

- **Bleeding**
- **Pain**
- **Infection**
- **Heart problems from the stress of the procedure**
- **Perforation or putting a hole in the colon. While such a complication would require surgery, the risk perforation is extremely small because this procedure only examines a portion of the colon and does not involve removal of polyps with cautery (burning).**

I also understand that the more common risks of any procedure include: infection, bleeding, nerve injury, blood clots, heart attack, allergic reaction and pneumonia. These risks are serious and possibly fatal.

3. ANESTHESIA: The administration of anesthesia also involves serious risks, most importantly a rare risk of reaction to medications causing death. I consent to the use of such anesthetics as may be considered necessary by the person responsible for there service except: none .
(If none, write "none")

4. ADDITIONAL PROCEDURES: If any physician discovers a different, unsuspected condition at the time of surgery, I authorize him or her to perform such other procedures as deemed necessary except:
none .
(If none, write "none")

5. RESULTS NOT GUARANTEED: I understand that no guarantee or assurance has been made as to the results of the procedure and that it **may not cure the condition.**

6. PATIENTS CONSENT: I have read and fully understand this consent form, and understand I should not sign this form if of all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form. I have no further questions.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED PROCEDURES OR ANY QUESTIONS CONCERNING THEM, ASK YOUR PHYSICIAN BEFORE SIGNING THIS FORM.

DO NOT SIGN UNLESS YOU HAVE READ AND THROUGHLY UNDERSTAND THIS FORM!

_____ _____
Witness Patient/ Responsible Party

_____ _____ am / pm
Date Time

PHYSICIAN DECLARATION: I have explained the contents of this document to the patient and have answered all the patient's questions, and to the best of my knowledge, the patient has been adequately informed. The patient has consented.

_____ _____ _____ am / pm
Physician's Signature Date Time