1. Health Condition and Proposed Examination
Your physician has informed you about your current medical condition.
It is:

_____

2. Diagnosis:
This diagnosis necessitates the performance of the above-mentioned procedure for diagnostic purposes.
A colonoscopy involves the insertion of a flexible instrument, known as a colonoscope, into the rectum to visualize and examine the interior of the colon. The procedure aims to identify abnormalities or assess the condition of your digestive tract. Sedation may or may not be required for the examination.

3. Potential Risks of a Colonoscopy
This diagnostic procedure involves certain risks and complications.

Common Risks and Complications:

- Moderate abdominal pain and bloating for up to five days post-procedure.
- Nausea and vomiting.
- Lightheadedness or dizziness, particularly upon standing.
- Headaches.
- Discomfort, redness, or swelling at the site of medication injection.
- Muscle soreness.
- Allergic reactions to administered medications.

Rare Risks and Complications (1 in 1,000 cases):

- Bleeding, particularly if polyps are removed or biopsies are performed, usually manageable with endoscopic treatment.
- Perforation of the colon, necessitating immediate surgical intervention.
- Heart and lung complications, such as aspiration or arrhythmias.

Very Rare Risks and Complications:

- Missed lesions or abnormalities due to incomplete bowel preparation.
- Bacteremia (infection in the blood), treatable with antibiotics.
- Severe allergic reactions to sedatives or medications used during the procedure.
- Anaphylactic shock, requiring emergency intervention.

4. Risks of Declining the Procedure
Your physician should outline specific risks associated with refusing this procedure. Additional notes may be included in your medical record if necessary.

_____

_____

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5. Patient Consent
I confirm that my physician has explained:

- My current medical condition and the necessity of the proposed diagnostic procedure.
- The risks, benefits, and alternatives to this procedure.
- The risks associated with not undergoing this procedure.

I have been given the opportunity to ask questions and discuss the procedure and its implications with my physician. All my questions have been answered to my satisfaction.
I understand that I can withdraw my consent at any time, even after signing this document.
I consent to the use of photographs or recordings taken during the procedure for medical diagnostic purposes.

6. Patient Declaration

Based on the information provided, I voluntarily consent to undergo the proposed colonoscopy procedure.

Patient Name:_____

Signature:_____

Date:____/_____/ _____

7. Physician Declaration

I confirm that I have thoroughly explained the procedure, including its purpose, potential risks, and alternatives, to the patient. I believe the patient has understood the provided information.

Physician Name:_____

Signature:_____

Date:____/_____/ _____