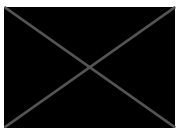
Consent for Case Report - Colon mucosal injury caused by water jet malfunction during a screening colonoscopy: Case report

Informed consent was obtained for this case report and patient consented verbally on 01/14/2022.

This was verified with the patient and confirmed the details about publication with deidentifying the information.

Parth Patel, MD

1/14/2022



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ENDOSCOPY DEPARTMENT REQUEST AND CONSENT FOR COLONOSCOPY and/or RELATED PROCEDURE

TO THE PATIENT:

As a patient, you have the right to be informed about your diagnosis, the recommended surgical, medical or diagnostic procedure to treat the condition, the risks associated with the recommended procedure, and the anesthesia you will need, and the availability of alternative treatments to help you make your decision about having the procedure.

My physician has recommended the following procedure: Colonoscopy / _____

1. **Description:** Colonoscopy is a procedure in which a flexible lighted tube is put into the rectum, so that the colon (large intestine can be examined. In addition, during the procedure, biopsies (small pinches or tissue) can be taken from the lining of the colon, and polyps can be removed. **Although usually the entire colon is examined, there are some times when this is not possible or necessary. Occasionally, there are instances when not all polyps are removed, depending upon their size and location.**

   Alternatives: Abdominal pain, rectal bleeding and screening for cancer can be done by having a barium enema x-ray (if this has not already been done). Polyps can be removed by surgery by removing part of the colon.

   Risks: Complications occur infrequently. Most patient have no complications from colonoscopy. Minor complications include, but are not limited to phlebitis (inflammation of a vein where medication was injected), abdominal distention and pain, and adverse reactions to medications, including low blood pressure or decreased breathing. More serious complications include bleeding, perforation (a hole in the colon) and infection. Bleeding occurs in approximately 100 out of 1000 cases, usually not requiring treatment, but rarely requiring blood transfusion or surgery. Perforation occurs in approximately 1 out of 1000 cases. This may require surgical repair and temporary colostomy while the hole is healing. Infections occurs in approximately 1 out of 2500 cases and might require treatment with antibiotics.

2. **Consent and Authorization.**
   I hereby consent to the performance of colonoscopy upon myself or [redacted]
   (patient name/relationship to patient)
   the above listed procedure by Dr. [redacted] and his or her associates/assistants, and other health care providers to perform the above procedure. I understand that among those who may provide care, assist in the procedure/operation, or observe the procedure are medical, nursing, or other health care personnel in training, and medical product representatives or technical consultants.

   I understand that other conditions or complications may occur during the procedure(s) or use of anesthesia that may require additional or different procedures than those proposed. I therefore authorize and request that the above named physician or my anesthesia provider perform such other procedures than he or she thinks is necessary and/or advisable in the exercise of reasonable professional judgment.

3. **Anesthesia/Sedation.** My physician has recommended the use of anesthesia or sedation during my procedure to provide certain pain relief during the procedure. I understand that the use of anesthesia or sedation may require my physician or anesthesia provider to insert a breathing tube to protect my airway for breathing. If my physician recommends sedation, I understand that the sedation used may be deemed minimal, moderate or deep. Depending on the level of sedation received, I may experience a change in my ability to respond to verbal commands, to move my body easily, and to breathe on my own.

   Further, I understand that anesthesia or sedation involves additional risks and consequences associated with its use such as stopping or markedly slowing of the heart and breathing, allergic reactions, possible brain injury or even death. In addition to these risks, other risks associated with the use of general anesthetics include throat discomfort or injury to the vocal cords (which may affect my ability to speak), teeth, dental work, or eyes; and risks associated with the use of spinal or epidural or other regional anesthetics include, but are not limited to, headaches, backaches, nerve damage, brain damage, or even death.

DO NOT WRITE BELOW THIS LINE

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[redacted] [redacted]

ENDOSCOPY DEPARTMENT REQUEST AND CONSENT FOR COLONOSCOPY and/or RELATED PROCEDURE

I have been advised of the reasonable and available alternatives, if any, to the proposed anesthesia or sedation. I consent, authorize, and request the administration of such anesthesia or sedation as is deemed necessary and advisable by my anesthesia or sedation provider.

4. **Tissue and Special Testing.** I consent to the examination, use and disposal by Barnes-Jewish West County Hospital of any tissue, or fluids that may be removed during the procedure. In the event of exposure of my bodily fluid(s) or tissue to any individual(s) involved in my care, I consent to having any bodily fluid(s) and/or tissue obtained and submitted for any testing deemed reasonable by my health care providers. I consent to having the results of these tests made available to any health care provider(s) who was or may have been exposed to such fluids and/or tissue.

5. **Pictures.** I consent to the storage and taking of pictures, video and/or electronic images in the course of the procedure for the purpose of medical education or training; provided, however, that my identity may not be revealed by any pictures or by descriptive text accompanying any photographs or images. I understand that reasonable efforts will be made to conceal my identity if the pictures are used.

6. **Full Code Status.** I understand and agree that during the procedure and during the recovery period, full resuscitative efforts will be used if my heart or breathing should stop including, but not limited to, cardiopulmonary resuscitation. I will discuss with my physician and the hospital providers if I do not want any such resuscitation or other treatment used during the procedure or post-anesthesia period and complete any additional consent or documentation concerning the level, if any, of the therapeutic support to be provided during my procedure.

I HAVE READ THIS CONSENT AND AUTHORIZATION. I HAVE RECEIVED AN EXPLANATION OF THE RECOMMENDED PROCEDURE AND ANESTHESIA OR SEDATION FROM MY PHYSICIAN AND/OR ANESTHESIA PROVIDER AND HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS. I UNDERSTAND THAT I SHOULD NOT SIGN THIS CONSENT IF THE PROCEDURE AND THE ANESTHESIA OR SEDATION I AM TO RECEIVE HAS NOT BEEN EXPLAINED TO MY SATISFACTION OR IF I HAVE ANY QUESTIONS THAT HAVE NOT BEEN ANSWERED.

Review any questions that you may have with your physician. If you choose to consent, please sign this form.

[redacted] 9 21 08:45 Patient or Representative Signature: [redacted]
DATE TIME

If the patient does not sign, indicate relationship to patient: _____

[redacted] 9 21 08:45 Witness to Signature: [redacted] RN
DATE TIME

Responsible Practitioner Certification. I hereby certify that I have explained the nature, purpose, benefits, complications from, risks of, alternatives (including no treatment and attendant risks), likelihood of achieving goals of care and potential problems that might occur during recuperation, to the proposed procedure/operation, have offered to answer any questions and have fully answered all such questions. I believe that the patient/agent/relative/guardian fully understands what I have explained and answered. I certify that the procedure described in the permission section of this form is accurate.

4 8 21 _____ [redacted] [redacted]
DATE TIME SIGNATURE/TITLE *(REQUIRED)* PRINTED NAMED *(REQUIRED)*

DO NOT WRITE BELOW THIS LINE

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