London Scoping Centre Ltd.

310 Wellington Road
London, Ontairo N6C 4P4
Tel. 519-433-4700 Fax. 519-433-4702

CONSENT FORM

COLONOSCOPY / GASTROSCOPY / SIGMOIDOSCOPY

I hereby authorize Dr. _____ to perform:

- ❒ Colonoscopy/Sigmoidoscopy with possible polypectomy, biopsy, and/or tattooing of site.
- ❒ Gastroscopy with possible esophageal dilatation, biopsy, and/or polypectomy.

If any unforeseen condition arises in the course of the procedure, I further request and authorize the above named physician to do procedures in addition to, or different from those now contemplated, if in the physician's judgment it is advisable.

I consent to the administration of sedation if required.

I acknowledge that the procedure, has risks and possible complications. Those risks/complications include but are not limited to:

Colonoscopy/Sigmoidoscopy:

- Hemorrhage (bleeding)
- Perforation (puncture of the bowel requiring emergency operative intervention)

Gastroscopy:

- Hemorrhage (bleeding)
- Damage to teeth
- Aspiration (breathing in of liquids)
- Perforation (puncture of the esophagus requiring emergency operative intervention)

I acknowledge that the above are diagnostic procedures performed in the prevention/diagnosis of gastrointestinal problems but each has its limitations. While it happens very infrequently, 'lesions' such as polyps can be missed especially if the preparation of the gastrointestinal tract has been less than satisfactory.

I acknowledge that I have arranged transportation upon discharge and that the clinic is not responsible for my transportation.

I acknowledge that I have read and fully understand the above consent.

Date: _____/_____/_____
Day Month Year

_____ _____
Print Patient Name Signature of Patient

_____
Signature of Witness/Interpreter

RISKS AND COMPLICATIONS EXPLAINED BY: _____
Physician's Signature

1st - PATIENT VERIFICATION
- ❒ **FIRST AND LAST NAME**
- ❒ **DOB**
- ❒ **PROCEDURE** **Staff:** _____

2nd - PATIENT VERIFICATION
- ❒ **FIRST AND LAST NAME**
- ❒ **DOB**
- ❒ **PROCEDURE** **Staff:** _____

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PRE-ANESTHETIC PATIENT QUESTIONNAIRE

The following questions have been designed for use by the Anesthesiologist. The questionnaire is to be completed BEFORE the procedure. Please answer questions and return the completed sheet to the front desk.

PATIENT NAME	AGE	GENDER ☐ M ☐ F	WEIGHT ☐ lb ☐ kg	HEIGHT ☐ cm ☐ in	BMI

	Y	N		Y	N
1. Have you ever had chest pain?			21. Do you have, or have you ever had Hepatitis?		
2. Do you have angina?			22. Do you have any kidney problems / failure?		
3. Have you ever had a heart attack? If yes, when? _____			23. Do you use street drugs? (ie: cocaine) _____ Do you use Marijuana? (smoke or edibles)		
4. Have you ever had: ☐ heart surgery ☐ stent			24. Do you have diabetes?		
5. Do you have a pacemaker?			25. Do you have thyroid problems?		
6. Have you ever had high blood pressure?			26. Do you have anemia (low blood count)?		
7. Have you ever had pulse palpitations?			27. Do you have a bleeding disorder?		
8. Have you ever had a heart murmur?			28. Do you have seizures?		
9. Have you ever had a stroke, TIA, or mini stroke?			29. Do you have arthritis?		
10. Do you take pills to thin your blood? ☐ ASA 81mg ☐ Prescription blood thinner			30. Do you have any other medical diseases or issues? Please list: _____		
11. Do you take antibiotics before dental work?			31. Do you use alcohol? How frequently?		
12. Do you smoke? For how long? _____ How many per day? _____			32. Have you ever had previously a: ☐ Gastroscopy ☐ Colonoscopy If yes, when was the last time? _____		
13. Have you quit smoking? When? _____			33. Have you or a family member ever had any problems with anesthesia?		
14. Do you experience shortness of breath? ☐ with exertion ☐ with normal activity			34. Do you have dentures/caps/crowns/bridges? ☐ If yes, please indicate: _____		
15. Do you have: ☐ chronic bronchitis ☐emphysema			35. Do you have any loose teeth?		
16. Do you have asthma?			36. Is there any possibility of pregnancy?		
17. Do you have sleep apnea? Do you use a CPAP?			37. Do you have drug allergies? If yes, please list:		
18. Do you experience reflux, heartburn, or indigestion?			38. Are you currently taking medications? If yes, please list:		
19. Do you have stomach ulcers?					
20. Do you have: ☐ ulcerative colitis ☐ Crohn's disease					