

**Operative-Major Diagnostic or  
Therapeutic Procedure Consent Form**

1. I hereby authorize Dr. \_\_\_\_\_  
and/or such designees as may be selected by him or her to perform the following procedure(s):  
COLONOSCOPY POSSIBLE BIOPSY OR POLYP REMOVAL
2. The nature and purpose of the operation/procedure named above, expected benefits, possible alternative methods of treatment/diagnosis, risks involved and the possibility of complications have been explained to me. I have had an opportunity to ask questions and have had them answered to my satisfaction.
3. I understand that the following risks, among others, are associated with the procedure(s):  
Perforation or bleeding (possibly requiring surgery). Missing a cancer, reaction to the medication  
or unforeseen complication
4. I understand that Dartmouth-Hitchcock Medical Center (DHMC) educates and trains health care personnel, including physicians in approved post-graduate residency programs. I am aware that under the supervision of the teaching physician, and based on their ability and level of competence, some portions of my procedure may be performed by these individuals.
5. I understand that if certain surgical products or medical devices are required for my procedure, staff from that company may be present to provide technical assistance to the procedural team.
6. I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the procedure(s).
7. I understand that during the course of the procedure(s), unforeseen conditions may arise or be discovered which require the performance of additional procedures, and I hereby consent to the performance of such additional procedures as my physician believes to be necessary or advisable.
8. I hereby authorize the Dartmouth-Hitchcock Medical Center to dispose of or to retain for diagnostic, therapeutic, research, or educational purposes any tissues, organs, or body parts which are removed as a necessary part of the procedure(s). If used for research that requires knowledge of the patient's identity, a review board will determine whether specific consent from the patient is required; otherwise, the identity of the patient who provided the specimen will not be revealed.
9. I understand that transfusion of blood/blood products may be necessary. I acknowledge that, among other risks, there may be a risk of transfusion reaction and transmission of infectious diseases, such as hepatitis or HIV infection. I hereby consent to the transfusion of blood/blood products. This consent is valid for treatment of the current condition unless I revoke this consent in writing. This period shall not exceed one year.
10. If I have a Do Not Resuscitate Order, a Limited Therapy Order, or an Advance Directive, I have been given an opportunity to advise caregivers of my intent if life saving treatment is needed during this procedure.

\_\_\_\_\_  
Patient or person authorized to  
consent on patient's behalf

\_\_\_\_\_  
Date and Time  
Form Signed

\_\_\_\_\_  
Signature of Physician or designated  
associate provider

\_\_\_\_\_  
Date and Time  
Form Signed

**TELEPHONE CONSENT**

(For consent obtained via telephone, consent is granted for operative-major diagnostic procedure and anesthesia. An opportunity to discuss anesthesia and risks of anesthesia with an anesthesiologist has been offered.)

\_\_\_\_\_  
Signature of person obtaining telephone consent

\_\_\_\_\_  
Date and Time

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date and Time

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Person authorized to consent on patients behalf

\_\_\_\_\_  
Relationship to patient (legal guardian or parent  
for minor; health care agent, or legal guardian of  
adult patient otherwise unable to consent)