

Your Physician has requested for you to be Scheduled for a Colonoscopy. Enclosed you will find two pending forms a cancellation waiver and consent form. Both forms must be signed and dated completely. Please note all of these forms must be returned to our office in order to complete the scheduling process.

Please contact the office as soon as possible to schedule this procedure.
The office number is 407-422-3790 X 3010

Thank you

Jennifer
Scheduler

CONSENT FOR COLONOSCOPY

**Paul R. Williamson, M.D.,
Joseph T. Gallagher, M.D.,**

**Andrea Ferrara, M.D,
Samuel De Jesus, M.D.**

COLON & RECTAL CLINIC OF ORLANDO

I, the undersigned patient or patients legal representative consent and authorize Dr. _____ and whomever he/she may designate as his/her assistants, employees and agents, to perform upon me the procedure (s) described below.

I authorize and give my consent to my physician and to whomever he/she designates to perform upon the patient a COLONOSCOPY, WITH POSSIBLE POLYPECTOMY and/or BIOPSIES and/or DILATATION and/or TATTOOING. My physician has explained to me that this procedure involves: passing a tube into the rectum for the purpose of visualizing the large intestine with possible biopsy, removal of polyps, possible brushing (obtaining a specimen for study), dilation (stretching of a portion of the intestine), possible coagulation (stopping bleeding), possible decompression (removal of pressure) and/or photography/video.

If any unforeseen condition arises in the course of the procedure, calling in his/her judgement for procedures in addition to or different from those contemplated, I further request and authorize him/her to do whatever he/she deems advisable. These procedures may include and are not be limited to:

- | | | |
|--------------------|------------------------------|--------------------------|
| Pouchoscopy | Ileoscopy | Flexsigmoidoscopy |
| Vaginoscopy | Exam Under Anesthesia | Capsule Endoscopy |

I understand that there are some risks involved in this procedure that may include but are not limited to: hemorrhage(bleeding), perforation (poking a hole in the intestine), abdominal pain/discomfort, abdominal distention (bloating), explosion of intestinal gases, cardiac/respiratory complications, allergic drug reaction, and/or hypotension (lowered blood pressure).

The nature, purpose and necessity of the treatment/procedure, the possible alternative methods of treatment, the risks involved, and the possibility of complications in the treatment of my condition have been fully explained to me and I understand the same. I acknowledge that no guarantee or assurance has been made to me concerning the results of such procedures.

Patient name printed

Date

Signature of Patient/ or Legal Representative

Date

Signature of Witness

Date

COLON & RECTAL CLINIC OF ORLANDO

Paul Williamson, M.D., FACS Andrea Ferrara, M.D., FACS, Joseph Gallagher M.D, Samuel De Jesus, M.D
110 W. Underwood St. #A Orlando, FL 32806 407-422-3790 FAX #425-4358

Date: _____

Patients Name: _____

Is to be scheduled for a Colonoscopy with Dr. _____.

I have been informed that there is a \$100.00 charge for failure to give 72 hours notice if I have to cancel the appointment. I also understand that the insurance will not cover this fee and I will be responsible to pay this in full before I can be rescheduled.

Patients printed name

Patients signature

Staff / Witness signature