Oregon Endoscopy Center
3355 RiverBend Drive Suite 510 Springfield, OR 97477-8800
(541) 868-9500 (541) 685-5920 Fax

Patient:	Patient Test		
MRN:	000000000		
DOB:	1/1/1965	**Procedure:**	Colonoscopy
Gender:	Male	**Date:**	8/23/2023
Age:	58 year(s)	**Attending Physician:**	Test, Doctor

Colonoscopy with FMT Consent

COLONOSCOPY *with* FECAL MICROBIOTA TRANSPLANTATION (FMT) CONSENT

Fecal Microbiota Transplant (FMT) is administered to treat chronic (recurrent) or severe C. difficile (CDI), an inflammatory condition of the large intestine (colon). FMT consists of introducing normal bacterial flora contained in stool collected from a healthy donor into the diseased colon where the flora is missing.

I CERTIFY THAT:

1. The nature, purpose, risks, and benefits of this procedure have been discussed with me. I understand that the donor has been screened for a possible history of exposure to communicable infectious agents through a detailed health questionnaire and undergone blood and feces testing for occult infectious pathogens, as some infectious diseases may be silent or clinically undetectable.
2. My physician has discussed alternative treatments for recurrent CDI, including various antibiotic options, surgery, or no treatment, and I understand the risk and benefits of the alternative treatments. I understand that my condition could improve, worsen or stay the same with each alternative treatment option, including FMT. My physician has asked me if I want a more detailed explanation of the procedure, alternatives, and risks, and I either (a) was satisfied with the explanation given and did not want any more information or (b) requested and received, in substantial detail, further explanation of the procedure, alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment.
3. I understand that, at the current time, the cumulative experience with FMT is limited and that FMT is therefore considered investigational.
4. I have been fully informed of the risks and possible complications of FMT.

    Complications may include but are not limited to:

    I. Transmission of infectious organisms contained in the donor stool (bacteria, viruses, fungi, parasites)
    II. Allergic reactions to constituents (antigens) contained in the donor stool
    III. Mechanical complications related to the insertion
5. I understand that the outline above is not a complete list of potential complications and that unforeseen risks that have not been discussed with me may exist.
6. I acknowledge that my physician can make no guarantee or promise as to the outcome of my treatment.

I HEREBY AUTHORIZE AND PERMIT A PHYSICIAN OF EUGENE GASTROENTEROLOGY CONSULTANTS, PC, AND WHOEVER MAY BE DESIGNATED AS ASSISTANTS, TO PERFORM UPON ME A COLONOSCOPY with FMT, AND POSSIBLE POLYPECTOMY, BIOPSY OR CAUTERY. IF ANY UNFORESEEN CONDITION ARISES DURING THIS PROCEDURE, CALLING FOR ANY ADDITIONAL PROCEDURES, OPERATIONS, OR MEDICATIONS, I FURTHER REQUEST AND AUTHORIZE WHATEVER IS DEEMED NECESSARY. I AM AWARE THE PRACTICE OF MEDICINE IS NOT AN EXACT SCIENCE, AND I ACKNOWLEDGE NO GUARANTEES HAVE BEEN MADE TO ME CONCERNING THE RESULTS OF THIS PROCEDURE.

Signatures

Oregon Endoscopy Center
Eugene Gastroenterology Consultants, P.C.

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Patient or Legal Guardian Signature
08/23/2023 09:22 AM

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Staff Witness Signature
08/23/2023 09:22 AM