Oregon Endoscopy Center
Eugene Gastroenterology Consultants, P.C.
Oregon Endoscopy Center
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(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/Ileoscopy Consent

COLONOSCOPY/ILEOSCOPY CONSENT

I CERTIFY THAT:

1. I understand the information provided to me regarding colonoscopy/ileoscopy;
2. I have been fully informed of the risks and possible complications thereof;
3. I understand there may be alternative procedures or methods of treatment, and
4. 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.

I HEREBY AUTHORIZE AND PERMIT A PHYSICIAN OF EUGENE GASTROENTEROLOGY CONSULTANTS, PC, AND WHOMEVER MAY BE DESIGNATED AS ASSISTANTS, TO PERFORM UPON ME A COLONOSCOPY AND POSSIBLE POLYPECTOMY, BIOPSY OR CAUTERY. IF ANY UNFORSEEN 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

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

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