VR Surgical Associates, PA

Dr. Vincent A. Caldarola and Dr. Rachel Lovano
GENERAL SURGERY
COLON AND RECTAL SURGERY

(210) 614-3565
(210) 614-3563 (fax)

COLONOSCOPY
DISCLOSURE AND CONSENT
MEDICAL, SURGICAL, AND DIAGNOSTIC PROCEDURES

To the Patient: Your have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used and the risks and hazards involved. This disclosure is part of an initiative to ensure you are informed about your procedure and can determine to provide or withhold your consent to that procedure.

- I (we) voluntarily request **VINCENT A. CALDAROLA, M.D.** as my physician, and any associates, technical assistants and other health care providers that may be deemed necessary to treat my condition. This condition has been explained to me as the following: ___**Screening**_____

- I (we) understand the following surgical, medical and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedures: _____**COLONOSCOPY WITH POSSIBLE BIOPSY/POLYPECTOMY**

- I (we) understand my physician may discover other or different conditions which may require additional or different procedures than those planned. I (we) authorize my physician and any associates, technical assistants and other health care providers to perform other procedures which are advisable in their professional judgment.

- If an implant is used I (we) consent to the release of related information (including my social security number) to the manufacturer of the implantable device as required by law.

- I (we) understand no warranty or guarantee has been made to me as to the result or cure following the procedure.

- I (we) consent to the disposal by the appropriate authorities of any tissue or specimens which may be removed including a limb. Exception: _____

- I (we) have been informed by my physician of the rights and benefits associated with the possibility of a blood transfusion(s) and/or one of its components. I understand the risks and hazards involved with the use of blood products: fever, transfusion reaction (may include kidney failure, anemia, heart failure, Hepatitis, Acquired Immune Deficiency Syndrome/AIDS and other infections). It is understood these risks exist despite the fact the blood has been carefully tested. The alternatives to transfusion have been explained. The benefits or receiving blood or blood products and the risks and the consequences of not receiving this therapy have been explained to me. **Initials: _____ I (DO) (DO NOT) authorize the use of blood and blood products should they be necessary.**

- Just as there are risks and hazards in continuing my present condition untreated, there are risks and hazards related to the performance of the procedure planned for me. I (we) realize that common to surgical, medical, and/or diagnostic procedures are the potential for infection, blood clots in veins and lungs, hemorrhage, allergic reactions, and even death. I (we) also realize the following risks and hazards may occur in connection with this particular procedure:
  Initials: _____ Tearing and/or perforation of the wall of the colon; Perforation and increased bleeding with cauterization; Additional treatment and/or surgery; Other: _____
  _____

➢ ***Please See Flipside***

VR Surgical Associates, PA

Dr. Vincent A. Caldarola and Dr. Rachel Lovano
GENERAL SURGERY
COLON AND RECTAL SURGERY

- I(we) consent to photography and/or videotaping of the procedure(s) to be performed including appropriate portions of my body for medical, scientific, or educational purposes providing my identity is not revealed by descriptive texts accompanying the pictures or videotapes.

- I (we) agree to the possible presence of a scientific observer(s) during the procedure or course of care should my surgeon make such a request. I (we) understand the observer may not be associated with the hospital. I (we) release the facility, its agents, assigns and successors from any and all liability, which may result from the presence of a scientific observer(s) in the operating/procedure room.

- **Initials: _____ I (we) understand the following anesthetic is planned and voluntarily consent to this type of anesthesia:** ☐ General ☒ IV Sedation

- I (we) understand anesthesia/sedation analgesia involves additional risks and hazards, but I (we) request the use of anesthesia/sedation analgesia for the relief and protection from pain during the planned and/or additional procedures. I (we) realize the anesthesia/sedation analgesia may have to be changed, possibly without explanation to me (us).

- I (we) understand certain complications may result from the user of any anesthetic including respiratory problems, drug reaction, paralysis, brain damage or death. Other risks and hazards, which may result from the use of general anesthetics, range from minor discomfort to injury to vocal cords, teeth or eyes. I (we) understand other risks and hazards resulting from spinal or epidural anesthetics include headache and chronic pain.

- **Initials:** _____ I (we) verify I (we) have been informed by my physician about my condition, alternative forms of anesthesia/sedation analgesia and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved. I (we) believe I (we) have sufficient information to give this informed consent. I (we) have been given the opportunity to ask questions.

- I (we) certify this form has been fully explained to me. I (we) have read or have had this form read to me (us).

_____ _____am/pm _____
Signature of Patient/Legally Responsible Party **Time** **Date**

_____
(If an individual other than the patient, indicate relationship to patient/reason for patient's inability to sign)

/Vincent A. Caldarola, MD, FACS

_____ _____ _____
Witness/Physician Signature Date Time

See facility address below.

_____
Witness Address:
4499 Medical Drive, Ste 250
San Antonio, TX 78229

Physician Statement: I, the undersigned, have reviewed and discussed with the patient (or his/her legal representative) this form and its contents. I have discussed with the patient (or his/her legal representative) the likelihood of achieving care and treatment goals; reasonable alternatives to the proposed care and treatment, including the risks, benefits and side effects related to the alternatives, and the possible results of not receiving care and treatment; and if indicated, any limitations on the confidentiality of information learned about the patient.

➢ ***Please See Flipside***