



GI Consent to Operation or Other Medical Services

This is a read-only copy. You will sign a form like this before your procedure.

PATIENT: _____ DATE: _____ TIME: _____ a.m.
p.m.

1. I authorize the following to be performed upon myself:

- _____ **Colonoscopy** with possible biopsy and/or polypectomy to include the possible use of electrocautery. This examination involves the passage of a long, flexible instrument through the rectum to view the lining of the entire large bowel with moderate sedation.
- _____ **Esophagogastroduodenoscopy (EGD)** with possible biopsy and/or dilation. This exam involves the passage of a long, flexible instrument through the mouth to view the esophagus, stomach and the duodenum with moderate sedation and/or topical anesthesia.
- _____ **Flexible Sigmoidoscopy** with possible biopsy and/or polypectomy with possible use of electrocautery. This examination involves the passage of a long, flexible instrument through the rectum to view the lining of the large bowel with moderate sedation.

This procedure(s) will be performed and/or directed by Cigna Medical Group Dr. _____ and/or associate _____

I confirm that the physician has informed me of the following:

- a. The nature, purpose and possible risks of the procedure(s) as well as alternative methods of treatment. Risks include but are not limited to, bleeding, puncture of gastrointestinal tract and side effects of the medication used.
 - b. That the explanation that I have received is not exhaustive and that other, more remote risks may arise.
 - c. I understand and do not desire further explanation.
 - d. I acknowledge that I have received no guarantees or assurances from anyone as to the results that may be obtained, including the possibility of undetected lesions such as polyps or cancer.
2. I consent to the use of sedation, as may be necessary and advisable to achieve moderate sedation. I understand that moderate sedation may involve some risk, even though administered in a careful manner. I further understand that a patient should not drive, operate equipment or drink alcoholic beverages for at least 24 hours after sedation.

3. I understand that Cigna HealthCare of Arizona (Cigna) and its Cigna Medical Group (CMG) Physicians and Health Professionals participate in training programs. Some patient services may be provided by persons in training under the supervision and instruction of CMG physicians. These persons may also observe care given to the patient by CMG physicians. I understand that I may request not to participate in any such training program.
4. I consent to the performance of procedures in addition to or different than those now contemplated, whether or not arising from presently unforeseen conditions, which the above named doctor and/or Health Professional may consider necessary or advisable in the course of the procedure.
5. I consent to photographing during the procedure for documentation in my medical record and that these photographs may be used by the physician or the Health Professionals for the advancement of medical education. I understand that my identity will not be revealed outside of my personal medical record.
6. I understand CMG Physicians and CMG Health Professionals are employees of Cigna and have no financial or vested interest the Cigna Medical Group Endoscopy Suite.

Patient Signature: **This is a read-only copy. Do not sign now.** Date: _____ Time: _____

Witness: _____ Date: _____ Time: _____

This certifies that this patient is a minor (son, daughter) or unable to sign, because of:

Parent/Guardian: _____

Witness: _____ Date: _____ Time: _____

File: Legal

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