Hartford Hospital
A Hartford HealthCare Partner

6816

Authorization for
Fecal Transfer with Colonoscopy/Endoscopy/Sigmoidoscopy

Patient's Name: _____

I hereby authorize Dr._____ to perform the following surgery/ procedure/treatment:

- ❑ Colonoscopy with polypectomy and / or biopsy / and/or fecal transfer
- ❑ Upper endoscopy with biopsy or dilatation, if indicated
- ❑ Flexible sigmoidoscopy with biopsy / polypectomy

I understand that residents, medical students, physician assistants and/or advanced practice registered nurses may also be in attendance, and/or assisting in the performance, and/or performing significant medical/surgical tasks within the above specified surgery and/or special procedure/treatment. In addition, I understand that there may be unforeseen circumstances that are encountered while performing the above listed surgery and/or special procedure/treatment that require the assistance of other qualified medical personnel who have not been identified.

I have had explained to me in connection with the proposed surgery/procedure/treatment: (i) the nature and purpose of the proposed surgery/procedure/treatment; (ii) the foreseeable risks and consequences of the proposed surgery/procedure/treatment, including the risk that the proposed surgery/procedure/treatment may not achieve the desired objective; (iii), the alternatives to the proposed surgery/procedure/treatment and the associated risks and benefits to such alternatives; and (iv) the reasonably foreseeable risks and alternatives to the transfusion of blood and blood products should I need a blood transfusion.

Specifically, in obtaining my informed consent to the surgery and/or special procedure, I have been informed of the following reasonably foreseeable risks:

- Organ puncture / need for emergency surgical repair.
- Blood vessel damage / bleeding.
- Minor complications include dental injury and sore throat.
- Heart or lung problems, needle site irritation, nausea, vomiting and sleepiness from sedation / analgesia
- There is a small possibility of a missed diagnosis.
- Complications may occur even when a procedure is properly performed.

_____Patient initial

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As I am undergoing fecal transfer for recurrent Clostridium difficile infection, I am aware of the rare potential for transmission of infectious diseases from my family donor despite appropriate screening for potential pathogens including CMV and EB V. I also understand this therapy may not succeed with the first procedure. Fecal microbiota collected from healthy individuals is being investigated for use in the treatment of C. difficile infection. Published data suggest that the use of fecal microbiota to restore intestinal flora may be an effective therapy in the management of refractory C. difficilie infection. However, the efficacy and safety profiles of this intervention have not yet been fully evaluated in controlled clinical trials. This procedure is not FDA approved and is considered investigational.

I am aware that, in addition to the reasonably foreseeable risks described, there are other foreseeable risks, which have been discussed with me, but are not listed. I affirm that I understand the purpose and potential benefits of the proposed treatment and/or special procedure, that no guarantee has been made to me as to the results that may be obtained, and that an offer has been made to me to answer any of my questions about the proposed surgery/procedure/treatment.

I agree to the use of anesthesia and/or sedation/analgesia as required, and if applicable, the disposal of any tissue removed.

I also authorize the Hospital and the above-named physician(s) to photograph, video and /or use any other mediums which result in the permanent documentation of my image for medical, scientific or educational purposes, provided my identity is not revealed by them. I agree that any photographs taken pursuant to this authorization, which are not required by law to be retained, may be disposed of by the Hospital so long as the manner of disposition shall be permanent destruction.

This consent may be revocable by me at any time, except to the extent it has already been relied upon.

_____M. D. Signed: _____
(Patient or legally authorized representative)

Date: _____Time: _____ Date: _____ Time: _____

Interpreter responsible for explaining procedures and special treatment:

_____ Date: _____ Time: _____
(Interpreter)

PATIENT UNABLE TO SIGN PRIOR TO SURGERY [□] BECAUSE:

_____

_____ M.D. _____ Witness

Date: _____ Time: _____ Date: _____ Time: _____