Dean P. Pappas, M.D., FACS, FASCRS
Frank J. Caliendo, M.D., MHCDS, FACS, FASCRS
Mala Balakumar, M.D. FACS, FASCRS
Cesar E. Sanz, M.D., FACS, FASCRS
Sarah Bibi Soleh, M.D., MRCS, FCPS, FACS, FASCRS
Bradley G. Bute, MD, FACS, FASCRS
E. Bryan Buckingham, MD
Grace L. Halleran PA-C

Locations in Nassau, Suffolk and Queens

Patient's Name ____________________________________Date of Birth___________________________

Home phone # _______________________________ Cell Phone #__________________________________

Today's date_______________

How did you hear about our practice? *(check all that apply)*

____ Referred by provider. Provider's name _______________________________________

____ Internet Search. Did you visit our website? Yes ____ No____

____ Family member or friend. Family member or friend's name______________________

What is the reason for today's visit? ____

Date of your last colonoscopy? ____

ARE YOU CURRENTLY TAKING? BLOOD THINNERS: YES____ NO ____ ASPIRIN: YES____ NO____

HEIGHT ______ WEIGHT ______lbs.

Past Medical History (check all that apply)

_Abdominal Aortic Aneurysm
_AIDS
_Amenorrhea
_Arthritis
_Asthma
_bleeding disorder
_breast cancer
_bruising tendency
_CAD (Any Cardiac Issues?)
_cervical cancer
_CHF
_Cholangiocarcinoma
_clotting disorder
_colon cancer
_COPD
_Crohn's Disease

516-248-2422
www.CRSSNY.com

Dean P. Pappas, MD, MBA, FACS, FASCRS
Frank J. Caliendo, MD, MHCDS, FACS, FASCRS
Mala Balakumar, MD, FACS, FASCRS
Cesar E. Sanz, MD, FACS, FASCRS
Sarah Bibi Soleh, MD, MRCS, FCPS, FACS
Grace L. Halleran, PA-C

Locations in Nassau, Suffolk and Queens

INFORMED CONSENT FOR ANORECTAL PROCEDURES

You may undergo an anoscopy or proctosigmoidoscopy as part of your rectal examination. These tests allow your doctor to look at the inner lining of your anus, rectum and the lower part of the colon. These tests are used to look for abnormal growths (such as tumors or polyps), inflammation, bleeding, hemorrhoids, and other conditions (such as diverticulosis).

You may be treated for one or more of the following conditions:
• Hemorrhoids
• Anorectal lesions
• Anal fissure
• Perirectal abscess

Nature and purpose of proposed treatment
• Removal of painful and /or bleeding hemorrhoidal tissue; treatment of internal hemorrhoids with injection sclerotherapy, rubber band ligation and/or infrared coagulation
• Treatment of infection in perirectal area, with drainage and collection of any pus
• Treatment of anal fissure including anal dilatation
• Removal of anorectal lesions

Risks common to all surgical procedures:
• Injury to a blood vessel or excessive bleeding
• Infection, which may require the use of antibiotics. In rare cases, another procedure may be necessary including exam under anesthesia at the local hospital

Risks and possible complications of the proposed treatment:
• Pain after procedure, which may require the use of pain medication
• Bleeding • Infection that may require the use of antibiotics. In rare cases, another procedure may be necessary
• Recurrence which may require another surgical procedure

I acknowledge and understand that prior to any procedure being performed, more specific instructions will be given to me. A diagnosis will be explained and I will have an opportunity to ask questions and have those questions answered. The procedure will proceed only when a verbal informed consent and this written informed consent have been obtained. I understand the above information and give my consent to have the described treatment performed.

______________________	______________________	__________
Print Name	Patient/Guardian Signature	Date