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Grace L. Halleran PA-C

Locations in Nassau, Suffolk and Queens

Patient's Name _____ Date of Birth _____

What is the reason for today's visit? _____

ARE YOU CURRENTLY TAKING? BLOOD THINNERS: YES _____ NO _____ Medication: _____

ASPIRIN: YES _____ NO _____

Diabetic or Weight loss medications: YES _____ NO _____ Medication: _____

Any Surgery since last visit: YES _____ NO _____

Please sign: _____ Date: _____



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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.

This consent remains valid **as long as I am under the care of any CRSSNY physician**, or until I rescind my consent in writing.

Print Name

Patient/Guardian Signature

Date