Consent for Colonoscopy and Sedation

To the Director of Tokyo Midtown Medical Clinic

～Attention～
Please fill this form with a ballpoint pen.

ID:
名前:

I have read the below document and fully understood the purpose, content, and risks of the colonoscopy and sedation. I consent to undergo the procedure on my free will, with the understanding that the procedure results cannot be completely guaranteed, as the practice of medicine involves uncertainties.

(Please check the following items that apply ☑)

Understanding the contents of the colonoscopy guide

- ☐ 1. Purpose and overview 1) Bowel preparation 2) Insertion of the scope 3) Observation of the colon 4) Biopsy and polypectomy
- ☐ 2. Preparation before the colonoscopy 1) Diet 2) Regular Medication
- ☐ 3. Precautions after the procedure
- ☐ 4. Sedation
- ☐ 5. Possible complications and risks
- ☐ 6. Other considerations
- ☐ 7. Alternative examinations
- ☐ 8. Right to withdraw consent
- ☐ 9. Medications which must be discontinued before the procedure

Preference for sedation

☐ **I wish to undergo sedation** (*I will not drink alcohol or drive vehicles until 6 am the next morning)

☐ Sedation is used to alleviate anxiety and discomfort. However, as its effects vary among individuals, sedation may sometimes be insufficient. For safety reasons, it is not possible to administer more than the appropriate dosage, and I understand this.

- ☐ **I do not have glaucoma**
- ☐ **I have glaucoma (Please check the next section)**

☐ **I do not want sedation**

Patients with glaucoma (including suspected cases or high intraocular pressure) or increased cupping of optic disc

☐ I have consulted an ophthalmologist and have been permitted to undergo sedation.

☐ I have received permission from the ophthalmologist and I elect to undergo sedation.

※Please bring the relevant documents (medical certificate), or consult with an ophthalmologist in person or by phone.

[Date: Name of the Ophthalmology Clinic: Name of Doctor:]

Patients with high fall risk (e.g., use of wheelchair or cane, difficulty walking due to injury, illness, or age)

We recommend that somebody accompany you home since the sedation will further increase your risk of falling.

☐ I have a companion to go home with (your companion:_____e.g., husband)

☐ I understand all the risks mentioned above and I do not need a companion.

Patients with cerebral aneurysm 4 mm or larger

☐ I have consulted a neurosurgeon and have been permitted to undergo the colonoscopy.
(within 3 months of the colonoscopy)

☐ I have received permission from a neurosurgeon, and I agree to undergo the colonoscopy.

※Please bring the relevant documents (medical certificate), or consult with a neurosurgeon in person or by phone.

[Date: Name of the Neurosurgery Clinic: Name of Doctor:]

following next page

【Biopsy】If an abnormality is found or suspected

☐ I consent to a biopsy

Biopsy (1-3 organs): Approx. 4,000-15,000 yen (covered by insurance)
※You will be charged 100% of the fee if you forget your health insurance card. (Refundable by bringing the card to the clinic within the same month.)
※You will be charged 200% of the fee if you do not have Japanese Health Insurance (Approx. 35,000-100,000 yen).

☐ I do not want a biopsy

【Polypectomy】If the doctor determines that polyp removal is necessary

● If you are undergoing the Colonoscopy Dock Course, the polypectomy will be considered as outpatient care.

☐ I consent to a polypectomy

(You cannot board an airplane or bullet train, drink alcohol beverages, or perform strenuous exercises for 7 days after the polypectomy.)

Polypectomy + pathology: 20,000-45,000 yen + Dock arrangement fee 11,000 yen
※You will be charged 100% of the fee if you forget your health insurance card. (Refundable by bringing the card to the clinic within the same month.)
※You will be charged 200% of the fee if you do not have Japanese Health Insurance (Approx. 100,000-220,000 yen).

☐ I do not want a polypectomy

Those currently undergoing cancer treatment or currently suffering from cancer

☐ I have confirmed with my doctor that endoscopic examination and biopsy are possible.

☐ I would like to undergo endoscopic examination and biopsy at the discretion of my doctor.

※ Please confirm whether or not the endoscopy/biopsy is possible by bringing documents (medical certificate, etc.) or by consulting or calling your attending physician.

[Date: Name of Clinic: Name of Doctor:]

Patients with neuromuscular diseases (myopathy, myositis, myasthenia gravis, etc.) ※No allowed colonoscopy for patients with ALS.

☐ I have confirmed with my primary physician that I can undergo colonoscopy and sedation.

☐ Based on my primary physician's decision, I would like to undergo colonoscopy and sedation.

※ Please bring the relevant documents (medical certificate) to undergo the endoscopy and sedation before the procedure.

[Date: Name of Clinic: Name of Doctor:]

Other conditions

☐ I have not had an abdominal surgery (laparotomy, laparoscopy, C-section) within 6 months

☐ I have not had an endoscopic submucosal dissection (ESD) of the upper gastrointestinal tract (esophagus, stomach, duodenum) within 2 months

☐ I weigh less than 130 kg on the day of the examination

☐ My blood pressure value on the day of examination is less than BP180/110 mmHg

☐ My intraocular pressure is less than 25 mmHg on the day of the examination and I do not have any eye pain.

☐ I am not actually or suspected of pregnancy.

(Signature of Explainer) ※staff use only						
Doctor (or Nurse)	Date	/	/	Time	:	Signature
Doctor (or Nurse)	Date	/	/	Time	:	Signature
【Signature of Patient】						
Date (yyyy/mm/dd)		/	/	Time	:	Signature
【If the patient is unable to consent , parent or legal guardian needs to sign】						
Date (yyyy/mm/dd)		/	/	Time	:	Signature
emergency contact number				(Relationship		)