Gastroenterology of the Rockies

303.604.5000
www.gastrorockies.com

Consent Form for Hemorrhoid Treatment by Infrared Coagulation

I consent to having a Hemorrhoid Treatment by Infrared Coagulation.

Infrared Coagulation (IRC) is mostly performed in an office setting to treat hemorrhoids. It is the preferred method of choice, because it is efficient, well tolerated by most patients, and has limited side effects. A small probe contacts the area above the hemorrhoid, exposing the tissue to a burst of infrared light for about a second. This coagulates the veins above the hemorrhoid causing it to shrink and recede. The patient may feel a sensation of heat very briefly, but it is generally not painful.
Anesthetic is usually not required.

I understand there are risks associated with Hemorrhoid Treatment of Infrared Coagulation, such as rectal pain, hemorrhoid thrombosis or bleeding, and/or anal fissure or anal abscess.

_____has explained the procedure and its risks to me, along with alternative diagnosis and treatment. I have been allowed to ask questions and have received answers to my questions concerning the planned examination.

I authorize the performance of the following procedure by or under the direction of the following physician. I have read and fully understand this consent form, and understand I should not sign this form if all items, including all of my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form.

PATIENT'S ACCOUNT NUMBER: _____

PATIENT'S NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE:_____DATE: _____

WITNESS RELATIONSHIP_____

I have explained the contents of this document to the patient and have answered all the patient's questions, and to the best of my knowledge, I feel the patient has been adequately informed and has consented to this procedure.
PHYSICIAN (print): _____

PHYSICIAN SIGNATURE_____ DATE: _____