

CONSENT FOR CT VIRTUAL COLONOSCOPY



Name: _____ DOB: __ / __ / ____

Date of last Screening CT _____

General Acknowledgement

I acknowledge that this is a preliminary screening test which uses radiation. I understand that screening test results must be considered in light of my age, gender, risk factors and symptoms, if any.

I also acknowledge and agree to the following:

1. I am not pregnant.
2. It is my sole responsibility to pursue all appropriate and necessary follow-up treatment with my physician and other health care professionals. I and my heirs, executors and representatives hereby release, waive, discharge, hold harmless and indemnify Canada Diagnostic Centres and its agents, employees, members and directors from all liability (including without limitation, attorney's fees and costs) arising out of my failure to seek and pursue follow-up consultation, care and treatment, regardless of whether the CT screening tests are normal or abnormal.
3. The CT exam I will receive is not eligible for medical insurance reimbursement, and I am solely responsible for payment in full. Claim forms will not be submitted to my medical insurance carriers by Canada Diagnostic Centres.
4. It is my responsibility to contact my physician for follow up evaluation of any test results. The screening CT results will be mailed to me, and also a copy will be faxed to my personal physician.
5. Screening CT is NOT a substitute for a physical examination by my doctor.

Specific Acknowledgements

1. I understand that a Virtual Colonoscopy is an effective screening technique for demonstrating polyps of the colon greater than 10 mm in size, but that it does not replace colonoscopy if I have typical symptoms of colon cancer (ie: blood in the stool).

I understand the intent and purpose of my CT screening exam. All risks and alternatives have been explained to me and all questions have been answered to my satisfaction.

I have read and understood the information provided on this form, and I authorize and consent to the performance of the CT screening exam.

I request a copy of this authorization (please initial) _____

Signature of Patient

Print Name (Patient)

Date

Witness