INFORMED CONSENT FOR SIGMOIDOSCOPY

It is very important to us that you understand and consent to the treatment your doctor is providing and any procedure your doctor may perform. You should be involved in any and all decisions concerning surgical procedures your doctor has recommended.

Sign this form only after you understand the procedure, the anticipated benefits, the risks, the alternatives, the risks associated with the alternatives and all of your questions have been answered. Please initial and date directly below this paragraph indicating your understanding of this paragraph.

_____ _____

Patient's Initials or Authorized Representative Date

I, _____, hereby authorize Dr. _____and any associates or assistants the doctor deems appropriate, to perform a sigmoidoscopy.

The doctor has explained to me the potential benefits of the procedure to me, which helps my doctor diagnose the source of rectal bleeding, identify possible infections or tumors in my colon and diagnose and treat hemorrhoidal disease. However, I understand there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of the procedure. I also authorize the administration of sedation and/or anesthesia as may be deemed advisable or necessary for my comfort, well-being and safety.

The doctor has explained to me that a sigmoidoscopy is the insertion of a lighted tube into the rectum and up into the lower part of the colon to enable my doctor to see the inner surface and lining to the rectum and lower colon. Most commonly this procedure is performed if one is experiencing either bleeding, abdominal pain, or as a screening device if there is a history of colon cancer, diverticulosis, hemorrhoidal disease or a change in the caliber or character of stool.

The doctor has explained to me that in order to be adequately prepared for this procedure, I will have a prescribed regimen of laxatives/cathartics or enema. The insertion of the tube is accompanied by the introduction of air into the colon to distend the walls for a more complete examination. As my doctor navigates the normal twists and turns of the colon, I may experience some abdominal cramping or discomfort. I may also have the sensation of having to move my bowels. The recovery period from this procedure is immediate. I know I may experience some lightheadedness or abdominal discomfort for approximately five to ten minutes.

The doctor has explained to me that there are risks and possible undesirable consequences associated with any procedure including, *but not limited to* perforation and serious infection of the colon especially if a biopsy is performed, blood loss, transfusion reaction, infection, heart complications, blood clots, loss of or loss of use of body part, other neurological injury, nervous reactions which cause fainting or passing out and/or death. Abdominal cramping and pressure may occur during and shortly after the procedure. I understand that if I need blood or blood products these carry a risk of contracting HIV/AIDS, hepatitis or other diseases. Further, any of these risks or complications may require further surgical intervention during or after the procedure, which I expressly authorize._____

initial

In permitting my doctor to perform the procedure, I understand that unforeseen conditions may be revealed that may necessitate change or extension of the original procedure or a different procedure(s) than those already explained to me. I therefore authorize and request that the above-named physician, his/her assistants, or his/her designees perform such procedure(s) as necessary and desirable in the exercise of his/her professional judgment.

In the unlikely event that one or more of the above inherent complications may occur, my physician or covering physician will take appropriate and reasonable steps to help manage the clinical situation and be available to me and my family to address our concerns and questions.

The reasonable alternative(s) to the procedure have been explained to me. These alternatives include, but are not limited to, a barium enema (x-ray test).

I hereby authorize the doctor and/or hospital or surgical center to utilize or dispose of removed tissues, parts or organs resulting from the procedure authorized above.

I consent to any photographing or videotaping of the procedure that may be performed, provided my identity is not revealed by the pictures or by descriptive texts accompanying them. I consent to the admittance of students or authorized equipment representatives to the procedure room for purposes of advancing medical education or obtaining important product information.

By signing below, I certify that I have had an opportunity to ask the doctor all my questions concerning anticipated benefits, material risks, alternative therapies, and risks of those alternatives, and all of my questions have been answered to my satisfaction.

_____ _____ _____/_____

Signature of Patient or Authorized Representative | Relationship | Date Time

❑ The Patient/Authorized Representative has read this form or had it read to him/her.

❑ The Patient/Authorized Representative states that he/she understands this information.

❑ The Patient/Authorized Representative has no further questions.

_____ _____/_____

Signature of Witness | Date Time

CERTIFICATION OF PHYSICIAN:

I hereby certify that I have discussed with the individual granting consent, the facts, anticipated benefits, material risks, alternative therapies and the risks associated with the alternatives of the procedure(s).

Physician:_____ Date/Time_____/_____

USE OF INTERPRETER OR SPECIAL ASSISTANCE

An interpreter or special assistance was used to assist patient in completing this form as follows:

_____Foreign language (specify)

_____Sign language

_____Patient is blind, form read to patient

_____Other (specify)_____

Interpretation provided by _____
(Fill in name of Interpreter and Title or Relationship to Patient)

_____ _____/_____
Signature (Individual Providing Assistance) Date Time