

FLEXIBLE SIGMOIDOSCOPY

Flexible sigmoidoscopy involves passing a lighted flexible tube (sigmoidoscope) through the anus into the lower intestinal tract (colon). This procedure allows the practitioner to examine the inside of the lower two feet of the colon. Sometimes small tissue growths (polyps) are removed during the sigmoidoscopy (polypectomy), as polyps can grow inside the colon and become cancerous. Occasionally biopsies (sampling of small pieces of colon) are performed during the sigmoidoscopy. Bleeding sites may be treated during the sigmoidoscopy by injection of sclerosing material or use of electrocautery. On rare occasions a narrowing or obstruction may be encountered during the sigmoidoscopy. The narrowing may be stretched (dilated) at the time of sigmoidoscopy.

Patient's
Initials

- _____ The details of the procedure including the anticipated benefits and material risks have been explained to me in terms I understand.
- _____ Alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me.
- _____ I understand and accept that the most likely material risks and complications of flexible sigmoidoscopy have been discussed with me and may include but are not limited to:
- *bleeding*
 - *gassy discomfort/bloating*
 - *infection*
 - *need for surgery*
 - *pain*
 - *perforation*
- _____ I have informed the doctor of all my known allergies.
- _____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.
- _____ I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.
- _____ I am aware and accept that no guarantees about the results of the procedure have been made.
- _____ I have been advised of the probable consequences of declining recommended or alternative therapies.
- _____ I have been informed of what to expect postoperatively, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.
- _____ I understand that any tissue/specimen removed during the surgery may be sent to pathology for evaluation.
- _____ The doctor has answered all of my questions regarding this procedure.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct _____, with associates or assistants of his or her
(practitioner's name and title, i.e., M.D., N.P., P.A.)

choice, to perform a flexible sigmoidoscopy on _____
at _____ . (patient name)
(name of facility)

I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

Patient or Legal Representative Signature/Date/Time

Relationship to Patient

Print Patient or Legal Representative Name

Witness Signature/Date/Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

Physician Signature/Date/Time

initial copy given to patient

initial original placed in chart

SAMPLE