First Hill
SURGERY CENTER

Flexible Sigmoidoscopy
Consent Form

Patient Name: _____ Date of Birth: _____

Guardian Name (if applicable): _____ Patient ID: _____

Washington State law guarantees that you have both the right and the obligation to make decisions regarding your health care. Your physician can provide you with the necessary information and advice, but as a member of the health care team, you must participate in the decision making process. This form acknowledges your consent to treatment recommended by your physician.

1 MY PROCEDURE

I hereby give my consent for Dr. _____or his/her associates or assistants to perform a ***Flexible Sigmoidoscopy*** *upon me. I understand the procedure is to be performed at First Hill Surgery Center. This has been recommended to me by my physician in order to* ***examine the lower colon and rectum for abnormalities.***
I understand that the procedure or treatment can be described as follows:
Flexible sigmoidoscopy is the viewing of the lower 1/3 of the colon and rectum with a sigmoidoscope which is a small diameter flexible tube inserted into the rectum and colon. Usually patients remain awake during the exam. Rarely sedation is administered, but this would be determined ahead of time. If indicated during the exam, small pieces of tissue or tissue growths (polyps) may be removed or biopsied. Abnormal bleeding areas may be treated by injection of medication or cautery. Photos via the scope may be taken.

2 MY BENEFITS

Potential benefits of flexible sigmoidoscopy include the possible diagnosis and treatment of certain lower gastrointestinal tract diseases and problems. While flexible sigmoidoscopy is an effective test to evaluate the lower 1/3 of the colon, not all colonic diseases or problems can be diagnosed with this procedure.

3 MY RISKS

I understand that there are ***potential risks, complications and side effects*** *associated with any surgical procedure. Although it is impossible to list all of them, I have been informed of some of the possible risks, complications and side effects of this procedure.*

Although uncommon, potential complications from flexible sigmoidoscopy include, but may not be limited to, injury of the colon including perforation, bleeding from polyp removal or biopsy and allergic or adverse reaction to medications, if any medications are administered.

Despite a good bowel preparation, colon polyps can be missed despite a careful examination. Because flexible sigmoidoscopy is an exam of the lower 1/3 of the colon, diseases and polyps in the upper 2/3 of the colon may not be detected.

Some of these risks, complications and side effects are not serious or do not happen frequently. Although these risks, complications and side effects may occur only very rarely, they do sometimes occur and cannot be predicted or prevented by the physician performing the procedure.

Sedation involves risk of complications and serious possible damage to vital organs such as brain, heart, lung, liver and kidney, and that is some cases may result in paralysis, cardiac arrest and/or brain death from known and unknown causes. Sedation will affect your judgment for

several hours. Patients need to arrange an escort home after the exam and are not allowed to drive until the next day.

4 **TISSUE DISPOSAL/PATHOLOGY**

Any tissue or specimen removed from the colon will be submitted to the pathologist for evaluation.

5 **MY CONSENT**

Although most procedures have good results, I understand that **no guarantee** has been made to me about the results of this procedure or the occurrence of any risks, complications and side effects.

I recognize that during the course of treatment, unforeseeable conditions may require **additional treatment or procedures**.

I request and authorize my physician and other qualified medical personnel to perform such treatment or procedures **as required**.

I have chosen to undergo this procedure after considering the **alternative forms of diagnosis and/or treatment** for my condition including no treatment or other procedures or tests. Alternatives to this procedure may include, but are not limited to observation, colonoscopy, barium enema, CT colonography or other imaging studies. These alternative forms of treatment have their own potential risks, benefits and possible complications.

I certify that I have read or had read to me the contents of this form.

I have read or had read to me and will follow any patient instructions related to this procedure.

I understand the potential risks, complications and side effects involved with the proposed **Flexible Sigmoidoscopy** and have decided to proceed after considering the possibility of both known and unknown risks, complications, side effects and alternatives to the **Flexible Sigmoidoscopy.**

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I consent to the above procedures as deemed necessary or appropriate by my physician or credentialed provider.

Patient Signature: _____ Date: _____ Time: _____

Patient is unable to consent because _____. I therefore consent for the patient.
Authorized Consenter's Signature: _____ Date: _____ Time: _____
Printed Name: _____ Relationship to Patient: _____

☐ Mark this box if telephone consent

Witness Name: _____
PRINT NAME

Witness Signature: _____ Date: _____ Time: _____

By my signature below I attest to the fact that I explained the procedure to the patient.

Physician Name: _____
PRINT NAME

Physician Signature: _____ Date: _____ Time: _____