Gastrointestinal and Liver Specialists of Tidewater, PLLC
Consent for Flexible Sigmoidoscopy

Patient's Name: _____

Procedure Date: _____ Acct #: _____

D.O.B: _____ Performing Dr: _____

Authorization and Nature of this Procedure: I hereby request and authorize **DR. _____** and his/her designated associates/assistants to perform a **flexible sigmoidoscopy and possible polypectomy or biopsy**. It has been explained to me that this procedure is an examination of the lining of the lower portion of the large intestine (colon) by use of a flexible scope, which is passed through the rectum into the colon. During this procedure biopsies (tissue samples) may be removed. If a polyp is detected which is removable, it will be removed with or without the use of electrocautery. I understand that there are several techniques to remove polyps/lesions and I authorize my physician to utilize whichever method he feels is best suited during this procedure. Small polyps are sometimes cauterized without tissue removal. Occasionally when bleeding occurs, cautery or the injection of medication may be necessary to stop the bleeding. I am also aware that sometimes the physician will mark the area of the colon that was treated, so that this area can be more easily re-evaluated in the future.

Risks and Complications: Every medical procedure has some degree of risk and the possibility of complications. My physician has explained to me and I understand that complications from this procedure include but are not limited to: a perforation or hole in the colon, bleeding, infection, rarely rupture of the spleen or irregular heart beat. Very rarely, death has been reported with this procedure. I understand that unusual complications, so rare that they are not routinely discussed before this test occasionally do occur. I do not wish to have any further explanation given to me, although I have been advised that I am entitled to do so if I desire. I understand that I may be transferred to another facility in the event that a complication occurs. This decision will be made by my physician or designated health care provider.

Alternative Procedures or Treatment: My doctor has explained to me that alternative procedures are available which also include risks and complications. Such options may include x-rays, barium enema, CAT scan, or no treatment. I am satisfied with my physician's explanation of these options and wish to proceed with a colonoscopy.

Attendance of other Health Care Providers: I understand that physicians, nurses and assistants may be present to perform and assist with my sigmoidoscopy. I consent to the presence of these health care professionals and **I do____/I do not____** consent to *students/residents/personnel in training* to be present during my procedure.

Photographs: I understand that photographs and/or videotaping may be taken during my procedure for documentation of findings. **I do____/I do not ____** consent to the use of these photographs to be used for teaching purposes. This may include the reproduction of the photographs for publication or to be used in part of a medical education program.

Tissue Disposal: I consent to the appropriate disposal of any body tissues (if any are removed during this procedure) after a pathologist has examined the same tissue.

Anesthesia/Sedation: Most of the time, no sedation is given for this procedure. However, if my physician feels that there will be circumstances present which would require the use of sedation to successfully complete this procedure, I consent to the administration intravenous (IV) medications that will have a sedative effect on me. Possible complications from this may include but are not limited to pain during the administration of medications, soreness/swelling in the arm, cardiac or respiratory arrest, rarely an allergic reaction, which could cause death. I understand that I cannot drive after the procedure (until the following morning), should not sign any legal or important papers or perform tasks that require coordination. I should have a responsible adult with me for the remainder of the procedure day.

No Guarantee or Assurance: I acknowledge that no guarantee or assurance to the outcome of this procedure has been given to me. I do recognize that this is the best test for finding lesions in the colon; however, I understand that there is a low percentage of missed lesions (about 2-5%) associated with this procedure.

No ADVANCE DIRECTIVES: I acknowledge that this facility does NOT recognize advance directives. During my care at this facility, all practical measures will be utilized to prevent loss of life. _____ (patient initial or signature)

Opportunity for Further Information: I understand that I am free to seek advice from other physicians if I choose. I know that I am also encouraged to ask questions regarding any aspect of this procedure, which I am unclear or unsure of.

Opportunity to Read this Document: I acknowledge by signing this consent that I have read this form in its entirety and fully understand it. I have had my questions answered to my satisfaction and agree and consent to this treatment.

DO NOT SIGN IF YOU HAVE FURTHER QUESTIONS

_____ _____

Signature of Patient or Authorized Person Date

Authorized person's relationship to the patient: _____

_____ _____

Signature of Witness Date

The above procedure(s) have been explained to the patient or authorized person to give consent for the patient.

_____, M.D.

Signature of Physician