Affix Patient Label	
Patient Name:	Date of Birth:

Informed Consent: Flexible Sigmoidoscopy

This information is given to you so that you can make an informed decision about having a **flexible sigmoidoscopy.** This procedure is most often done with moderate sedation or anesthesia.

Reason and Purpose of this Procedure:

This procedure allows the doctor to look at the inside of your rectum and sigmoid colon. The sigmoid colon is the lower part of your large intestine. The doctor will insert a long flexible tube called a colonoscope through your anus and into your colon. The scope will introduce air into your large intestine to get a better view. The scope has a camera and light on the end that will show images on a screen and save the pictures if needed. Small growths, called polyps, may be removed during the procedure. Other biopsies may also be taken during the procedure.

To find the cause of:

- Rectal pain.
- Abdominal pain.
- Change in bowel habits.
- Blood in stools.

To look at your colon before the procedure. To evaluate the healing of rectum and colon:

- After you have had surgery.
- After you have had chemotherapy or radiation treatment.
- After you have been treated for cancer.
- Look for lesions in the lower part of the colon and rectum.

Benefits of this Procedure:

You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- Better assessment for treatment of condition.
- Find the cause of current symptoms.
- Early detection of cancer.

Risks of this Procedure:

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

- Pain or discomfort. You can discuss pain control options with your doctor.
- Cramping and bloating. This is temporary.
- Difficulty having bowel movements. This is temporary.
- Rectal bleeding. This may require treatment.
- Possible injury to the bowel. This may require treatment.
- Possible injury to the bowel. This may require surgery to correct.

Risks Associated with Smoking:

Smoking is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks Associated with Obesity:

Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks Specific to You:

____

____

____

____

Alternative Treatments:

Other choices:

- Other testing like colonoscopy, radiological testing (x-ray).
- You can decide to have this procedure under anesthesia.
- Do nothing. You can decide not to have the procedure.

If you Choose not to have this Treatment:

- Underlying conditions may go undiagnosed and untreated.
- May require emergency surgery.

Information on Moderate Sedation:

You will be given medicine in an IV to relax you. This medicine will also make you more comfortable. This is called "moderate sedation". You will feel sleepy. You may even sleep through parts of your procedure. We will monitor your heart rate and your blood pressure. We will also monitor your oxygen level.

If your heart rate, blood pressure or oxygen levels fall outside the normal range, we may give medications to reverse the sedation. We may be unable to reverse the sedation. We may need to support your breathing.

Even if you have a NO CODE status:

- You may need intubation to support your breathing.
- You may need medications to support your blood pressure.

We will re-evaluate your medical treatment plan and your NO CODE status when sedation has cleared your body.

Benefits of Moderate Sedation:

You might receive the following benefits. Your doctor cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- Less pain during the procedure.
- Less anxiety or worry.
- Decreasing your memory of the procedure.

Risks of Moderate Sedation:

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect. The list includes:

- Decreased breathing during the procedure and dropping oxygen levels. To help you breathe, a tube may be placed

into the mouth or nose and into the trachea to help you breathe.
- Allergic reactions: nausea & vomiting, swelling, rash.
- Vomit material getting into the lungs.
- A drop in blood pressure. This needs fluids or medicine to increase blood pressure.
- Heart rhythm changes that may require medicines to treat.
- Not enough sedation or analgesia resulting in pain or discomfort.

Your physical and mental ability may not be back to normal right away. You should not drive or make important decisions for at least 24 hours after the procedure.

General Information:

During this procedure, the doctor may need to perform more or different procedures than I agreed to.

During the procedure, the doctor may need to do more tests or treatment.

Tissues or organs taken from the body may be tested. They may be kept for research or teaching. I agree the hospital may discard these in a proper way.

Students, technical salespeople, and other staff may be present during the procedure. My doctor will supervise them.

Pictures and videos may be taken during the procedure. These may be added to my medical record. These may be published for teaching purposes. My identity will be protected.

Affix Patient Label

Patient Name: Date of Birth:

By signing this form, I agree:

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with the doctor. My questions have been answered.
- I want to have this procedure: **Flexible Sigmoidoscopy** ____
  ____
- I understand that my doctor may ask a partner to do the procedure.
- I understand that other doctors, including medical residents or other staff may help with the procedure. The tasks will be based on their skill level. My doctor will supervise them.

Provider: This patient may require a type and screen or type and cross prior to procedure. If so, please obtain consent for blood/products.

Patient Signature: ____ Date: __________ Time: __________

Relationship: ☐ **Patient** ☐ **Closest relative (relationship)** ___________ ☐ **Guardian/POA Healthcare**

Reason patient is unable to sign: ____ ☐ Telephone Consent Obtained

First Witness Signature: ____________ Second Witness Signature: ___________ Date: __________ Time: __________

(One witness signature MUST be from a registered nurse (RN) or provider)

Interpreter's Statement: I have interpreted the doctor's explanation of the consent form to the patient, a parent, closest relative or legal guardian.

Interpreter's Signature: ________________________________ ID #: __________ Date: __________ Time: __________

For Provider Use ONLY:

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Provider signature: ____ Date: ___________ Time: __________

Teach Back:

Patient shows understanding by stating in his or her own words:

_______ Reason(s) for the treatment/procedure: ____

_______ Area(s) of the body that will be affected: ____

_______ Benefit(s) of the procedure: ____

_______ Risk(s) of the procedure: ____

_______ Alternative(s) to the procedure: ____

OR

_______ Patient elects not to proceed: ______________________________ Date: ___________ Time: ___________

(Patient signature)

Validated/Witness: ____ Date: ___________ Time: ___________