# Informed Consent Therapeutic Enema for Intussusception

This information is given to you so that you can make an informed decision about your child having **Therapeutic Enema for Intussusception**

**Reason and Purpose of the Procedure:**

Intussusception is a condition where one part of the intestine slides into another, like a telescope. The intestine becomes inflamed. This can cause a blockage. This condition most commonly occurs in children 3 months to 24 months of age. Intussusception is a medical emergency.

Therapeutic Enema for Intussusception is done by inserting a tube into your child's rectum and using air to create pressure and "un-telescope" the intestine. This relieves the obstruction. X-rays of the abdomen are used to guide the provider during the procedure. While the air is being inserted, your child may feel abdominal pressure or light cramping, which most children are able to tolerate. If needed, intravenous relaxing and pain medications may be used.

**Benefits of this procedure**:

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

- The procedure is minimally invasive with rare complications.
- Your child is able to avoid surgery to correct the blockage.

**Risks of 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.

- **Injury to the bowel**. This is rare. If this occurs, your child may need surgery to repair.
- **Reactions to the intravenous relaxing or pain medications may occur.** Your child will be monitored. Further treatment may be needed.
- **The air enema may not work to resolve the obstruction.** If so, your child will require surgery to treat the intussusception.

**Risks specific to your child:**

____________________________________________________________

____________________________________________________________

____________________________________________________________

**Alternative Treatments**:

Other choices:

- Surgery

**If you choose not to have this treatment:**

- The blockage may get worse. Your child may need emergency surgery to correct.

**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.

Students, technical sales people and other staff may be present during the procedure. My child's doctor will supervise them.

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

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: **Therapeutic Enema for Intussusception**
- I understand that my doctor may ask a partner to do the biopsy.
- I understand that other doctors, including medical residents or other staff may help with biopsy. 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 surgery. If so, please obtain consent for blood/products.

Patient Signature________________________________________________Date:__________Time:__________

**Relationship: ☐Patient/Parent of minor ☐Closest relative (relationship) ☐Guardian/POA Healthcare**

**Interpreter's Statement:** I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.

Interpreter: ____________________________________________________Date___________Time___________

Interpreter (if applicable)

**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 the 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: ________