

## INFORMED CONSENT FOR SIGMOIDOSCOPY

### Explanation of Procedure

Direct visualization of the sigmoid colon with lighted instruments is referred to as sigmoidoscopy. The following information is presented to help you understand the reason for and the possible risks of the procedure. At the time of your examination, the lining of the anus, rectum and the left side of the colon, usually to the depth of approximately 60cm or 25 inches will be inspected. If an abnormality is seen or suspected, a small portion of tissue (biopsy) may be removed or brushed. These samples are viewed by a pathologist under a microscope to determine if abnormal cells are present. Generally, sedation is not given for this procedure and some discomfort may be experienced.

### Principal Risk and Complications of Sigmoidoscopy

Sigmoidoscopy is generally a low risk procedure. However, all of the complications below are possible and your physician will discuss their frequency with you. You must ask your physician if you have any unanswered questions about your procedure.

1. **PERFORATION:** Passage of the instrument may result in an injury to the sigmoid colon wall with possible leakage of sigmoid colon contents into the body cavity. If this occurs, surgery to close the leak may be required.
2. **BLEEDING:** Bleeding, if it occurs, is usually a complication of biopsy. Management of this complication may consist only of careful observation, but may require blood transfusions, hospitalization or possibly a surgical operation.
3. **OTHER:** This includes complications from other diseases you may already have. You must inform your physician of all your allergies and medical problems. Death is a rare and infrequent complication.

### Alternatives of Sigmoidoscopy

There is not an alternative to sigmoidoscopy. X-ray examinations are not able to see this portion of the colon well.

I certify that I understand the information regarding SIGMOIDOSCOPY. I have been fully informed of the risks and possible complication of my procedure. I hereby authorize and permit «USName» and whomever he may designate as his/her assistant to perform the sigmoidoscopy. If any unforeseen condition arises during the procedure calling for additional procedures or treatments, I authorize him/her to do whatever he deems advisable. If surgery is required, I realize I must be transferred to another facility for this. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me concerning the result of this sigmoidoscopy.

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Date	Time	Signed by patient or legally authorized person
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Date	Time	«USName»
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«PName»	«PNumber»	«PDOB»	«USName»
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