Informed Consent for Flexible Sigmoidoscopy

Name: ___________________________________      Procedure Date: _____________  Time: ___________

1. I, ____________________________________________ (patient or guardian) give consent for
   Dr._____________________________________ or his/her associates to perform a flexible sigmoidoscopy with
   possible biopsy, removal of polyp(s) with possible coagulation/injection therapy of blood vessels or tissue, and
   control of bleeding if necessary.

2. I understand this procedure involves the passage of a digital optic instrument through the rectum to
   allow the physician to visualize the interior of the large intestine (colon). I understand that this is a limited
   examination and only visualizes the last few feet of the colon. Sedation and pain relieving medications may
   be given to minimize discomfort and relax me for the procedure. These medications may cause localized irritation
   and/or a drug reaction. I understand that if I receive anesthesia/sedation for this procedure I will not be able
   to drive the remainder of the day and I should not have plans after the procedure. I understand that I MUST
   HAVE A DRIVER take me home.

3. I understand the reasons for the procedure which have been adequately explained to me by my
   physician. I understand I may call the office where I regularly see my physician with any questions about the
   preparation or procedure. I have had ample opportunity to ask questions before signing this consent.

4. RISKS: Possible complications of this procedure include, but are not limited to: bleeding and tearing
   or perforation of the bowel wall. These complications, should they occur may require surgery, hospitalization,
   repeat sigmoidoscopy, and/or a transfusion. Perforation of the bowel is a known, but rare complication which
   can occur at a rate of 1 per 1,000 sigmoidoscopies. Bleeding, usually after a polyp removal, can occur at a rate
   of 1 per 1,000 sigmoidoscopies and continue up to two weeks after a polyp is removed. Other extremely rare,
   but serious or possibly fatal risks include: difficulty breathing, heart attack, and stroke. Polyps, especially small
   ones, can be missed 5-10 percent of the time, and in rare cases a colon cancer can be missed. Sigmoidoscopy
   does not guarantee that you will not develop colon cancer, but removing polyps is documented to significantly
decrease your risk of colon cancer in the future.

5. I understand there are no guarantees regarding the results of this procedure. Alternative options as
   deemed medically relevant have been discussed and may include fecal occult blood tests and/or radiologic
   imaging tests. I understand that these tests have their own limitations and benefits.

6. I have read and fully understand this consent form, and understand that I should not sign if all of my
   questions have not been answered to my satisfaction or if I do not understand any of the words or terms used
   in this form. IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED PROCEDURE
   OR TREATMENT, ASK YOUR PHYSICIAN NOW, BEFORE SIGNING THIS CONSENT FORM. DO NOT SIGN UNLESS
   YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.

________________________________________         ______________               ______________
Patient/Legal Representative signature                        Date               Time

________________________________________         ______________               ______________
Witness signature                                                             Date                Time