

WASHINGTON SQUARE ENDOSCOPY CENTER, LLC
230 West Washington Square
Philadelphia, Pennsylvania 19106

Patient Name: _____

Date of Birth: ____/____/____
mm dd year

CONSENT FOR FLEXIBLE SIGMOIDOSCOPY

DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS

INTRODUCTION: Your doctor, _____, has scheduled you for an examination of the sigmoid colon or large intestine using a flexible tube (flexible sigmoidoscopy), which is an examination of the sigmoid colon by means of a flexible, fiberoptic instrument (endoscope) inserted into your rectum to examine your sigmoid colon. The flexible sigmoidoscopy is being done for the following reason(s):

_____.

The intravenous sedation may be provided for the following reasons: _____

_____. Your doctor has scheduled you to have the procedure in an ambulatory surgery center so that you may benefit from the following:

- The same high quality of care provided to hospital inpatients.
- A pleasant atmosphere in which you can feel relaxed and confident about your procedure.
- A shortened recovery time resulting from the techniques used for the procedure and the intravenous sedation.
- The convenience of spending less time away from home and work and reducing the interruption to your daily schedule.

The physician(s) responsible for the performance of the flexible sigmoidoscopy is (are): _____

If I choose not to have the flexible sigmoidoscopy, your future medical condition (prognosis) is: _____

_____.
We are asking you to read and sign this form to indicate that you understand the procedure and its benefits, and accept its risks. Please ask any questions about the procedure or this form that you do not understand.

PROCEDURE: The flexible sigmoidoscopy then will be inserted through your rectum to examine your sigmoid colon. If your physician determines it is necessary, an intravenous may be started for intravenous sedation. If given, the sedation will be light enough that you may respond to spoken requests, but you may not remember the examination. Your sigmoid colon will be examined in detail and samples (biopsies) may be taken. At the time of the flexible sigmoidoscopy, additional procedures may also be performed including: removal of polyps, stretching or narrowing (or stricture) and/or heater probe of a bleeding site. The examination will take approximately 30-60 minutes with a 30-60 minute recovery period.

RISKS: In general, flexible sigmoidoscopy is a safe test, but there are some risks associated with the procedure and with the use of intravenous sedation. The risks associated with the procedure range from minor discomfort to significant medical problems. Following the procedure, many patients note bloating and cramping that lasts from 1 to 3 hours. The significant medical risks include: 1) bleeding; and 2) perforation of the colon or rectum. These complications may be serious and may necessitate hospital admission, antibiotics, transfusions or surgery. In addition, there have been reports of serious, unpredicted complications culminating in death. The possibility of missing a significant diagnostic finding also exists.

The risks of intravenous sedation include: 1) inflammation or bruising (phlebitis) at the site of the intravenous; 2) allergic reaction (such as hives, wheezing, anaphylaxis); and 3) problems with cardiac and pulmonary function (irregular heartbeat and slowed breathing).

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The additional risks associated with flexible sigmoidoscopy being performed in an ambulatory surgery center are as follows: _____

ALTERNATIVES: There may be other alternatives to flexible sigmoidoscopy that your physician could use to help diagnose your problem, including x-rays or surgery.

An alternative to having flexible sigmoidoscopy performed in an ambulatory surgery center is to have flexible sigmoidoscopy performed in a hospital.

An alternative to intravenous sedation is _____.

If you are reluctant to have flexible sigmoidoscopy or the intravenous sedation, or if you are reluctant to have flexible sigmoidoscopy performed in an ambulatory surgical center, please discuss this with your physician.

AGREEMENT: By signing this consent form, I acknowledge that I have read or had this consent form read and/or explained to me, and that I understand the information contained in this consent form. I also acknowledge that I have been given an opportunity to ask my physician any other questions I might have and that my questions have been answered satisfactorily. I agree to have the procedure performed and accept the risks.

Signature: _____
PATIENT OR RELATIVE

DATE

Signature: _____
WITNESS

DATE

CERTIFICATION OF PHYSICIAN

I certify that I have discussed and explained flexible sigmoidoscopy with the above-named patient and, in my opinion, he/she fully understands what I told him/her and the matters set forth in this consent form, which he/she has signed voluntarily in my presence.

Signature: _____
PHYSICIAN

DATE