NORTH MISSISSIPPI MEDICAL CENTER

TUPELO, MISSISSIPPI

Consent Form for
Flexible Sigmoidoscopy (Flex Sig)

STAMP WITH ADDRESSOGRAPH

1. I hereby authorize, Dr. _____("my physician") and/or other physicians designated by him/her and the employees and staff of North Mississippi Medical Center, to perform a **Flexible Sigmoidoscopy (Flex Sig)** upon me, referred to as the "procedure". I understand that my physician will be assisted by other physicians and health care professionals considered necessary in my care. I agree to their participation in my care.

2. My physician has discussed with me the items that are briefly summarized below:

   a. **Procedure**: A procedure where a thin, lighted flexible tube (scope) with small video camera at the end is placed in the rectum and advanced to the lower third of your colon. The "scope" is slowly withdrawn and the colon is examined carefully. If any unusual areas are seen then a biopsy (removal of a small tissue sample) may be taken through the "scope" and sent to a pathological lab for testing. Treatment of other lesions may be performed through the "scope" as well. If growths (polyps) are found, they can often be taken out or treated through the scope by various techniques.

   The Flex Sig is usually performed with no sedation. After the test is completed, your doctor will discuss your findings and his recommendations with you. After the Flex Sig, you should be able to resume your usual activity.

   b. **Nature and Purpose of Procedure**: Usually a Flex Sig may be recommended for several reasons. Listed are the various reasons. I have circled the reason(s) that you are having the test:
      i. Blood in your bowel movement
      ii. Low iron anemia
      iii. Lower gastrointestinal bleeding
      iv. Colon cancer screening
      v. Colitis or follow up for colitis
      vi. Diarrhea
      vii. Rectal pain
      viii. Change in bowel habits
      ix. Rectal Ultrasound
      x. Other _____

   c. **Known Risks of the Procedure**:
      Risks common to any invasive procedure:
      i. Worsening of underlying medical condition which may require medical treatment
      ii. Aspiration of stomach content into the lung which may require further medical treatment
      iii. Neurological changes: coma, stroke which may require medical treatment
      iv. Complications associated with heart and lung disease
      v. Death

      Risks specifically associated with Flex Sig:
      i. Perforation-tearing of the rectum and intestines–which often requires immediate major surgery with a possible colostomy (bag on your side attached to your colon)
      ii. Bleeding from your rectum and colon which may require blood transfusions and additional surgery
      iii. Infection which may require medical treatment or surgical drainage
      iv. Drug reaction and/or trouble with sedation (if used) which may require medical treatment
      v. Other unpredicted consequences that may occur
      vi. Ability to reach the lower third of the colon is about 90-95%. The lack of the ability to reach the lower third of the colon can be due to a very tortuous (winding) of the colon, failure to empty the colon prior to the procedure, or pain or discomfort that requires the test to be stopped.

      Specific risks associated with my medical condition are as follows:

      _____

      _____

      _____

   d. **Alternatives to the Procedure**: The alternatives to the Flex Sig are as follows:
      i. Colonoscopy
      ii. Barium Enema
      iii. Observation with no test being done
      iv. Empiric treatment of the underlying condition or symptoms
      v. CT Colonoscopy

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e. **Predicted Outcome (Prognosis) with No Treatment**: The prognosis if the Flex Sig is not done may include the following:
   i. May not be able to treat the underlying problem effectively because the cause or extent of the problem is not known.
   ii. Failure to diagnose a non-cancerous polyp or a cancer
   iii. Curable cancer could spread due to lack of a diagnosis

f. **Anesthesia**: I have been told that the use of anesthesia adds additional risk to the procedure including respiratory (breathing) problems, drug reactions, paralysis, brain damage and death. Other anesthesia risk include discomfort or injury to the vocal cords, teeth or eyes.

3. Should a complication arise, I therefore authorize my physician, and/or other physicians designated by my physician and the employees and staff of North Mississippi Medical Center, to provide such medical treatment including additional surgery or procedures as are necessary and desirable in the exercise of professional judgement.

4. I appreciate and understand that there are certain risks associated with this procedure and I freely assume these risks. I also understand that there are possible benefits associated with this procedure. However, I understand there is no certainty that I will achieve these benefits. I have been informed and I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the outcome and results of the proposed procedure. I have been told that this procedure carries risks and that some of these risks may be serious.

5. I have had the opportunity to ask questions of my physician and/or physician's associates concerning my condition, and about the procedure, the alternatives and risks to the procedure, and my physician and/or physician associates have answered all questions to my satisfaction.

6. I authorize my physician and/or physician's associates and staff of North Mississippi Medical Center to permit other persons, including but not limited to students, interns, residents and representatives of medical equipment manufacturers to observe the procedure with the understanding that such observation is for the purpose of advancing medical knowledge.

_____
Initial

7. I certify that all blanks requiring insertion of information were completed before I signed this consent form.

8. I have read the two (2) pages of information. I acknowledge that the information I have received, as summarized on this form, is sufficient information for me to understand the risks and benefits of the procedure and to consent to and authorize the procedure described above. This procedure has been explained to me to my satisfaction. Risks, benefits and alternative treatments have been explained to my satisfaction. I understand that the explanations which I have received may not be exhaustive and all inclusive and that more remote risks not discussed may exist. I am signing this form freely and voluntarily indicating my agreement consent and authorization for this procedure.

_____ / _____ _____ / _____
Patient's Signature/Date (Witness to Patient's Signature/Date)

_____ /_____
If Patient is unable to consent, signature of Patient Representative signing and consenting on behalf of Patient. Date

I have explained the above procedure with the risks and benefits of the procedure to the above-named Patient or Patient's Representative. The Patient (Patient Representative) has acknowledged understanding the nature of the procedure with the risks and benefits and has consented to the procedure. I have answered all questions posed to me by the Patient (Patient Representative).

Physician _____ Date: _____