

ARAPAHOE GASTROENTEROLOGY
ARAPAHOE ENDOSCOPY CENTER

INFORMED CONSENT FOR FLEXIBLE SIGMOIDOSCOPY

I, _____
authorize Dr. _____ and any assistant(s)
he/she deems necessary to perform Sigmoidoscopy with possible biopsy and/or possible removal
of polyp, and other _____.

- 1.) I understand this procedure involves the following: Passage of fiber optic instrument through the rectum to allow the physician to visualize the interior of my lower portion of my large intestine (colon).
- 2.) **RISKS:** Possible complications of this procedure include but are not limited to: Bleeding, tearing or perforation of the bowel wall. These complications, should they occur, may require surgery and/or a transfusion (Estimated 1 per 10,000 procedures). Other risks which can be serious and possibly fatal include: difficulty in breathing, heart attack and stroke. These risks are extremely rare but may occur.
- 3.) I understand that there are no guarantees regarding the results of this procedure. Alternatives are _____.
- 4.) I have read and fully understand this consent form, and understand I should not sign this form if all items, including all of my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent 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.**

Witness

Patient/Responsible Party

Date/Time

- 5.) **PHYSICIAN DECLARATION:** I have explained the contents of this document to the patient and have answered all the patients' questions. To the best of my knowledge, I feel the patient has been adequately informed and has consented.

Physician's Signature

Date/Time