South Bay
Gastroenterology
Medical Group

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INFORMED CONSENT FOR FLEXIBLE SIGMOIDOSCOPY

1. 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 _____.

2. 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).

3. 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.

4. I understand that there are no guarantees regarding the results of this procedure. Alternatives are_____ _____ _____.

5. ALTERNATIVES: Liver tissue for diagnostic examination can also be obtained by looking into the abdominal cavity with a scope, which is called laparoscopy, by surgery and by radiology by threading a needle through a neck vein.

6. ANESTHESIA: A medicine causing numbness will be injected at the site of the biopsy. Sometimes an intravenous sedative will be given as well. No general anesthesia is needed.

_____	_____	_____
Witness	Patient/Responsible Party	Date/Time

7. 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