

**UNC HOSPITALS
CHAPEL HILL, NORTH CAROLINA 27514**

**REQUEST AND AUTHORIZATION FOR
FLEXIBLE SIGMOIDOSCOPY AND BIOPSY
MIN #181**

I request and authorize Dr. _____ and/or associates or assistants of his/her choice at The University of North Carolina Hospitals to perform a flexible sigmoidoscopy and biopsies on _____.
Patient's Name

Authorization is also given for control of bleeding, removal of abnormal growths, and dilation of abnormal areas of narrowing in my digestive tract.

Description of the Procedure: Flexible sigmoidoscopy will involve the insertion of a flexible, video/fiberoptic instrument called a sigmoidoscope into my rectum. The sigmoidoscope will allow physicians to view and examine the lining of my rectum and lower colon. I understand that there may be some mild cramping and gas-like pressure during the procedure.

If any abnormalities are seen, a biopsy may be performed. A biopsy involves the removal of a small sample of tissue through the sigmoidoscope, which will be examined by a pathologist.

Treatment procedures are often performed when sigmoidoscopy identifies a source of recent or active bleeding, a growth, or a narrowing of the digestive tract. These procedures may include treating the site of bleeding with an electrocautery, laser, heater probe, and/or injection of agents that cause blood to clot. An electrocautery is an instrument that directs a high frequency electrical current through an area of tissue. Electrocautery may also be used to remove growths or polyps in a procedure called a polypectomy. Narrow areas of my digestive tract may be enlarged by the use of balloons, dilating catheters, and/or bougies.

I understand that sedation is generally not required. Sigmoidoscopy can be performed within 10 to 20 minutes, and is well tolerated by most patients.

I understand that if sedatives such as midazolam, droperidol, demerol, or morphine are necessary, they will be given by intravenous line to cause relaxation and drowsiness. These medications also may cause a brief period of memory loss and result in my not having a recollection of the procedure.

Risks: I understand that complications are very rare. The following risks have been associated with sigmoidoscopy.

1. Perforation of the colon: A perforation or tear in the colon wall occurs in 1 per 10,000 sigmoidoscopies. If a perforation were to occur, it would be treated with antibiotics and/or surgery.

2. Bleeding: Minor bleeding following a biopsy occurs in 1 to 2 per 1,000 procedures. Excessive bleeding requiring hospitalization and/or transfusion may occur in 1 per 10,000 procedures.
3. Infection (Bacteremia): A small number of bacteria may enter the bloodstream during sigmoidoscopy. Patients with heart murmurs or artificial heart valves may be given antibiotics before a sigmoidoscopy to reduce the risk of infection of the heart valves.
4. Fainting: Some patients faint as a result of the procedure.
5. Other possible complications : Patients may rarely experience an unexpected, adverse drug reaction to the medications administered. Inflammation, mild abdominal discomfort, and bruising and infection at the intravenous site are other possible complications of flexible sigmoidoscopy.

Benefits: I understand that the purpose of a sigmoidoscopy is to gain information about the rectum and lower colon that may not be obtained by x-ray. The procedure is generally very safe and is well tolerated by most patients.

I understand that the purpose of a biopsy is to assist in diagnosis and treatment.

Alternative options: I understand that x-rays and surgery are the alternatives to a flexible sigmoidoscopy, and biopsy.

Statement of Voluntary Participation:

I have read the information contained in this form, and have had sufficient opportunity to discuss my medical condition and treatment with the undersigned physician. All of my questions have been answered to my satisfaction, and I believe that I have been given adequate information upon which to base an informed consent for a flexible sigmoidoscopy, biopsy, and other possible therapeutic procedures.

I am consenting to having a flexible sigmoidoscopy, biopsy, and other possible therapeutic procedures performed. I understand that I can withdraw my consent at any point. My consent for this procedure is voluntary.

I understand that during the course of the flexible sigmoidoscopy, biopsy, and other possible therapeutic procedures something may arise which may necessitate procedures in addition to or different from those described above. If such unexpected circumstances arise I further request and authorize the performance of additional operations or procedures which may be considered necessary or advisable by the undersigned physician and/or his/her associates or assistants.

I further request that the administration of such anesthetics as may be considered necessary, desirable, or advisable by the physician responsible for such service.

I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made concerning the performance, results or interpretation of the flexible sigmoidoscopy, biopsy, and other possible therapeutic procedures.

For the purpose of advancing medical education I give my permission for observers to be admitted to the operating room or procedure room, and UNC Hospitals and the UNC School of

Medicine staff to make and use any photographic or other illustrations of me for diagnostic, scientific, educational, or research purposes, provided that my identity is not revealed. I further authorize UNC Hospitals and the UNC School of Medicine staff to examine and dispose of any tissues or parts which may be removed and to use them for teaching, educational, or research purposes, provided that my identity is not revealed.

I confirm that I have read this form, or it was read to me, and that all blank spaces were filled in and all inapplicable paragraphs, if any, were stricken before I signed below.

_____ Date: _____

Signature of Patient/Person Authorized to Sign for Patient

_____ Printed Name

_____ Relationship to Patient

_____ Hospital Number

PHYSICIAN CERTIFICATION

I hereby certify that the patient has read, or had read to him/her, this form and I have explained the nature, purpose, usual and most frequent risks, benefits, and alternatives to the proposed flexible sigmoidoscopy, biopsy, and other possible therapeutic procedures. I have offered to answer questions, and fully answered any questions by the patient about the procedure. I believe that the patient understands this form and what I have explained, and has consented to the proposed sigmoidoscopy, biopsy, and other possible therapeutic procedures.

_____ Physician Signature

_____ Physician Name

Date: _____

WITNESS CERTIFICATION

I hereby certify that the patient has acknowledged to me that he/she has requested a flexible sigmoidoscopy, biopsy, and other possible therapeutic procedures, has received an explanation of the nature, purpose, benefits, usual and frequent risks and hazards of, and alternatives to the procedure, has had all of his/her questions answered, given his/her consent, and has signed the form above.

_____ Witness Signature

_____ Witness Name

Date: _____