MEDICAL RECORD	INFORMED CONSENT FOR PERFORMANCE OF PROCEDURE and REQUEST FOR SEDATION/ANESTHESIA

1. Condition to be treated: Flexible Sigmoidoscopy with possible polypectomy &/or biopsy
For: ____ Screening ____ Surveillance ____ Diagnostic ____Therapeutic

PROPOSED PROCEDURE

2. Description of the procedure: A flexible scope is inserted in the anus to inspect the rectum and partial colon.

3. Risks of the procedure: Inability to complete procedure, tearing tissue, bleeding, infection, altered vital signs, and Death.

4. Intended results of the procedure: Visualize the lower GI tract with a scope and identify problems. These problems/ polyps can often be addressed or removed with the scope during the procedure.

ALTERNATIVES TO PROPOSED PROCEDURE

5. Recognized alternatives to the proposed procedure: Radiology studies (Barium enema, virtual colonoscopy).

6. Risks and benefits associated with the alternatives: These radiologic studies use no sedation (and are safer), but cannot directly see the tissue and cannot treat any findings. Any findings will necessitate an endoscopic exam.

7. Risks associated with not undergoing any treatment or procedure: Continued symptoms, worsening of undiagnosed disease.

8. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of Tripler Army Medical Center.

9. Exceptions to surgery or anesthesia, if any are _____ ____ None
(If "none", so state)

10. I request the disposal by the medical facility of any tissues or parts which it may be necessary to remove.

11. I understand that photographs and videos may be taken of this operation, and that they may be viewed by various personnel. I consent to the taking and hard copy and electronic storage of such pictures.

12. COUNSELING PROVIDER: I have counseled this patient regarding the condition to be treated, the description of the proposed procedure, the intended and anticipated results and the risks of the proposed procedure, alternative treatments, if any, the risks and benefits of the alternative treatments, and the risks of undergoing no treatment.

_____
Signature of Counseling Physician/ Dentist

PATIENT'S IDENTIFICATION (For typed or written entries, give: Name –last, first, middle, ID no. (SSN or other); hospital or medical

Medical Record

SIGNATURES

(All items in this form must be completed before signing)

13. I have been informed of the condition to be treated, the description of the proposed procedure, the intended and anticipated results, and the risks of the proposed procedure, alternative treatments, if any, and the risks and benefits of the alternative treatments of the above named proposed procedure. I have been informed of the risks of undergoing no treatment.

I request the performance of the above-named proposed treatment or procedure and of such additional treatments or procedures as are found to be necessary or desirable, in the judgment of the professional staff, during the course of the operation or procedure. I acknowledge that no guarantees have been made to me concerning the results of the treatment or procedure. I acknowledge the above has been explained to my satisfaction, I have had the opportunity to ask my doctor questions, and my questions have been answered.

_____ _____

Signature of Patient *(Date / Time)*

14. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I am the parent, legal guardian, or other surrogate decision maker of the above named individual. I request the performance of the above-named proposed treatment or procedure and of such additional treatments or procedures as are found to be necessary or desirable, in the judgment of the professional staff during the course of the operation or procedure. I acknowledge that no guarantees have been made to me concerning the results of the treatment or procedure. I acknowledge the above has been explained to my satisfaction and I have had the opportunity to ask questions and my questions have been answered.

_____ _____ _____

Signature of Surrogate Decision Maker *(Date/Time)* *Relationship*

Universal Protocol Checklist

Pre-procedure verification confirmed correct patient, procedure, consent, positioning, side/site, blood products and special equipment (as applicable).

The procedure site was marked (or used alternate marking method). Note: not required for obvious wound/lesion, midline, single organ procedures, procedures without intended laterality (e.g., endoscopes and colposopies) or procedures in which there are no predetermined sites of insertion.

A Time-Out was performed immediately before the procedure noting the above as well as confirming the patient's position, relevant images and labs, antibiotics, fluids and safety precautions IAW MEDCIM Reg 40-54.

Team agrees on procedures to be done:

By: _____

And: _____

Date/Time: _____

PATIENT'S IDENTIFICATION (For typed or written entries, give: Name –last, first, middle, ID no. (SSN or other); hospital or medical

Medical Record