INFORMED CONSENT FOR COLON SURGERY

It is very important to us that you understand and consent to the treatment your doctor is providing and any procedure your doctor may perform. You should be involved in any and all decisions concerning surgical procedures your doctor has recommended.

Sign this form only after you understand the procedure, the anticipated benefits, the risks, the alternatives, the risks associated with the alternatives and all of your questions have been answered. Please initial and date directly below this paragraph indicating your understanding of this paragraph.

_______ _____________

Patient's Initials or Authorized Representative Date

I, ________________________________, hereby authorize Dr. _______________________and any associates or assistants the doctor deems appropriate, to perform upon me the following:

❑ Total Colectomy ❑ Subtotal Colectomy ❑ Hemicolectomy (Right / Left) ❑ Ostomy

❑ Ileostomy ❑ Colostomy ❑Colorectal Anastomosis ❑ Sigmoidectomy

❑ Low Anterior Resection ❑ Total Proctectomy ❑ Abdominal Perineal Resection ❑ Rectopexy

❑ Other____

❑ Open ❑ Laparoscopic

Brief Description of Colon Surgeries

Total Colectomy: Removal of entire colon.

Subtotal Colectomy: Resection of part of the colon or resection of all of the colon without complete resection of the rectum.

Hemicolectomy: Right hemicolectomy—resection of the ascending colon. Left hemicolectomy—resection of the descending colon.

Ostomy: An artificial opening on the abdominal wall through which waste material passes out of the body from the bowel or urinary tract. A **colostomy** is an ostomy that specifically opens from the colon. A colostomy requires an appliance (odor-proof bag) to collect waste material. A colostomy closure, or **colorectal anastomosis** is surgery to close a previous colostomy.

Ileostomy: Involves bringing the ileum (the last portion of the small intestine) to the abdominal surface. When waste matter reaches the ileum it is liquid, so an appliance (odor-proof bag) is needed to collect

it. However, a less comon type of ileostomy called a Koch's pouch or continent ileostomy does not require an appliance.

Sigmoidectomy: A resection of the sigmoid colon, sometimes including part or all of the rectum.

Low Anterior Resection: Removal of diseased or ruptured part of colon.

Total Proctectomy:

Abdominal Perineal Resection: Removal of the anus, rectum, and sigmoid colon and the creation of a permanent colostomy.

Rectopexy: This surgery uses sutures to reposition a prolapsing rectum.

The doctor has explained to me the potential benefits of colon surgery. However, I understand there is no certainty that I will achieve these benefits and no guarantee has been made to me regarding the outcome of the procedure. I also authorize the administration of sedation and/or anesthesia as may be deemed advisable or necessary for my comfort, well-being, and safety.

The doctor has explained to me that there are risks and possible undesirable consequences associated with the procedure including, but not limited to, bleeding, infection, injury to other organs, blood vessels, ureter(s), or bladder, a leak from the connection that is made between the two ends of the intestine (anastomotic leakage), temporary paralysis of small or large bowel, blood clots, hernia, obstruction of the bowel, infection, heart complications and death. I understand that if I need blood or blood products these carry a risk of contracting HIV/AIDS, hepatitis, or other diseases. Further, any of these risks or complications may require further surgical intervention during or after the procedure, which I expressly authorize._______
initial

In permitting my doctor to perform the procedure, I understand that unforeseen conditions may be revealed that may necessitate change or extension of the original procedure or a different procedure(s) than those already explained to me. I therefore authorize and request that the above-named physician, his/her assistants, or his/her designees perform such procedure(s) as necessary and desirable in the exercise of his/her professional judgment.

In the unlikely event that one or more of the above inherent complications may occur, my physician or covering physician will take appropriate and reasonable steps to help manage the clinical situation and be available to me and my family to address our concerns and questions.

The reasonable alternatives to the procedure have been explained to me. These alternatives vary depending on the underlying condition and may include but are not limited to, drug treatment of inflammatory bowel disease, attempted obstruction removal, and chemotherapy and/or radiation. I understand that these alternatives may be ineffective or significantly less effective than my prescribed treatment.

I hereby authorize the doctor to utilize or dispose of removed tissues, parts or organs resulting from the procedure authorized above.

I consent to any photographing or videotaping of the procedure that may be performed, provided my identity is not revealed by the pictures or by descriptive texts accompanying them.

I consent to the admittance of students or authorized equipment representatives to the procedure room for purposes of advancing medical education or obtaining important product information.

By signing below, I certify that I have had an opportunity to ask the doctor all my questions concerning anticipated benefits, material risks, alternative therapies, and risks of those alternatives, and all of my questions have been answered to my satisfaction.

____________________________________ ________________________ ________/______

Signature of Patient or Authorized Representative — Relationship — Date — Time

❑ The Patient/Authorized Representative has read this form or had it read to him/her.

❑ The Patient/Authorized Representative states that he/she understands this information.

❑ The Patient/Authorized Representative has no further questions.

___________________________________ ________/______

Signature of Witness — Date — Time

CERTIFICATION OF PHYSICIAN:

I hereby certify that I have discussed with the individual granting consent, the facts, anticipated benefits, material risks, alternative therapies and the risks associated with the alternatives of the procedure(s).

Physician:____ Date/Time____________/____________

USE OF INTERPRETER OR SPECIAL ASSISTANCE

An interpreter or special assistance was used to assist patient in completing this form as follows:

___________Foreign language (specify)

___________Sign language

___________Patient is blind, form read to patient

___________Other (specify)____

Interpretation provided by ____
(Fill in name of Interpreter and Title or Relationship to Patient)

____________________________________ ______________/________________
Signature (Individual Providing Assistance) Date Time