ICCS
Istituto Clinico Città Studi

etichetta paziente

Department of Gastroenterology and Diagnostic and Operative Digestive Endoscopy
Director: Dr. Paolo Beretta
Tel.: 02 2393 3055-3045-2252 - Fax: 02 2393 4240
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INFORMATION PROTOCOL AND REQUEST FOR CONSENT RECTAL SIGMOIDOSCOPY - RECTOSCOPY

PREPARATION TO THE EXAM

Mr/Ms _____

Is booked to come in on _____at_____

For a:

❑ **RECTOSCOPY** ❑ **RECTAL SIGMOIDOSCOPY**

PREPARATION:

- FOR TWO DAYS EAT A DIET FREE OF VEGETABLES, FRUIT AND WHOLEMEAL FOOD.
- THE EVENING BEFORE THE EXAM AND THE VERY MORNING OF THE EXAM, PRACTICE AN ENEMA WHIT A 133ML CLIMALAX BOTTLE
- THEN FAST

If patients require any further information or explanations, they can contact the **Digestive Endoscopy Service (Servizio di Endoscopia Digestiva)** on +39 02-2393 3045/3055, Email: endoscopia@ic-cittastudi.it

PLEASE READ CAREFULLY THE ATTACHED INFORMATION SHEET

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INFORMED CONSENT

In a doctor-patient relationship it is deemed necessary and ethically correct for the patient to play an informed and active role in invasive diagnostic examinations and treatments to which he or she submits voluntarily.

Hence, this document provides the information, and the doctor who presents and explains it to you will provide the extensive and clear information required to understand it, ensuring that you have clearly understood the contents submitted to your attention below, which require your final signature.

It is important for you to deem the information provided as exhaustive and clear and, particularly, for you to have clearly understood the procedure proposed for an appropriate therapeutic treatment. The benefits of the procedure that will be performed, the possible risks and any alternatives will be explained to you, so that you can make a voluntary and, therefore, an informed decision in this regard. Hence you are also given written information that is as detailed and as complete as possible, to ensure that the explanation is both comprehensible and exhaustive. If you deem it necessary, do not hesitate to request further information which you might consider useful to clear any doubts or to clarify any parts of the explanation that you did not fully understand. Hence, we invite you, before you give your written consent by signing this form, to clarify with the doctor who explains it to you, every aspect you have not fully understood.

I, the undersigned, _____ confirm that today I had an informative interview with Dr.

_____

who explained that due to my disease,

DIAGNOSIS

_____

it is necessary/appropriate to perform the following invasive procedure:

☐ **Rectoscopy** ☐ **Rectal sigmoidoscopy**

☐ I, the undersigned, **consent** to a **endoscopic polypectomy**

☐ I, the undersigned, **do not consent** to an **endoscopic polypectomy**

In this regard I have been exhaustively and comprehensibly informed about:

- my diagnosis resulting from the visit and/or examination;
- the most appropriate treatment, schedule and implementation methods;
- the potential benefits of the treatment;
- the possible complications, risks and related additional medical procedures;
- the possibility of failure;
- the particular risks related to my case;
- the discomfort that might arise after the treatment;
- the timeline and methods of recovery;
- the alternative therapeutic options to the diagnostic/therapeutic treatment proposed to me;
- including refusal to accept treatment and the related risks;
- the instruments required.

I also confirm:

- that I have had the opportunity to ask questions about the treatment proposed, and that the doctor was willing to provide any further clarifications I might require;

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- that I am aware of the possibility of having to sign a new form, if the treatment is divided into various appointments, depending on which hazards might arise for my health;
- that I have been informed about the option of withdrawing my consent, if I do not want to continue the treatment;
- that I am aware of the fact that when changes are required to the already agreed procedures, I will have to express my consent once again;
- that I have understood that, if required, a change in the surgical strategy that cannot be foreseen at this moment might be necessary during surgery.

Hence, I freely provide my informed consent to submit to the recommended treatment, having received the information required to evaluate its feasibility.

ACT OF CONSENT

With this statement, which shall be effective as the full, free and unconditional expression of my will, I, the undersigned, declare that I have received and understood the information briefly described above and presented in the enclosed technical document, and:

☐ **I give my consent**	☐ **I do not give my consent/I withdraw my consent**
Patient's signature, guardian/parent _____ Referring doctor's signature _____ *Examining doctor's signature* _____	Patient's signature, guardian/parent _____ Referring doctor's signature _____ *Examining doctor's signature* _____
Date: _____	

Details of the declaring party:

- ❑ patient
- ❑ guardian of the incapacitated patient
- ❑ parents of the minor patient exercising parental authority

use upper case to enter the first and last name and date of birth of the declaring party, if different to the patient:
_____

Signature of the other parent _____

Specify the name of the mediator / interpreter, if any _____

Sistema Sanitario Regione Lombardia

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DECLARATION OF PERSONAL PROPERTY MANAGEMENT

I, the undersigned_____

DECLARE

I have been informed by the designated staff that:

- Hospitals are exposed to the deplorable and distressing phenomenon of frequent thefts targeting patients.

- The Management has implemented various measures to prevent such occurrences (e.g., monitoring clinic access with surveillance cameras, etc.), but these measures are not always sufficient to completely eliminate the issue.

- The Management strongly advises all patients not to leave wallets, money, debit cards, credit cards, mobile phones, dentures, and other valuable items unattended. Furthermore, it recommends that all patients who have the opportunity to do so, entrust any unnecessary items (debit cards, credit cards, mobile phones, watches, cash, or other valuable belongings) to their family members or companions.

I ALSO DECLARE

that I do not have any valuable belongings with me and/or that I will personally manage any possessions I have, including any personal aids (such as eyeglasses, prostheses, canes, etc.).

I therefore release the facility and all its personnel from any liability in the event of loss.

Milan, _____ *Patient Signature* _____

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Milan, _____ *Patient Signature* _____