

INSTRUCTIONS FOR YOUR FLEXIBLE SIGMOIDOSCOPY

PROCEDURE LOCATION: Mackenzie Health Hospital, 10 Trench Street, Richmond Hill

PROCEDURE DATE: _____

ARRIVAL TIME: _____

PROCEDURE TIME: _____

- Upon arrival to hospital, go to PATIENT REGISTRATION (main floor) for self check-in process
- Once you have registered, go to the 5th floor ENDOSCOPY UNIT
- You will be at the hospital for a total of 2-3 hours (the procedure is 15 minutes)
- If you are receiving sedation, **it is MANDATORY that you arrange for a responsible adult to drive you home after the procedure.** If you do not have a ride arranged on the day of your procedure, your procedure will be cancelled, as per hospital policy.
- If you are receiving sedation, you CANNOT drive a vehicle or operate heavy machinery for 24 hours after your procedure, due to the potential side effects of the sedative given.

THINGS TO DO BEFORE YOUR FLEXIBLE SIGMOIDOSCOPY:

- Read all these instructions carefully and thoroughly
- Notify your surgeon's office if you are on a blood thinner medication (aspirin, Plavix, warfarin, rivaroxaban, apixaban, etc.)
- Arrange to have someone be your ride to and from the hospital
- Purchase the following from your pharmacy. There is no need for a prescription:

Sodium Phosphate Enema (Fleet enemas) x 2 packages

CANCELLATION POLICY

To cancel or reschedule an appointment, you must provide at least 3 business days' notice. Our late cancellation & no-show fee is \$200.00. Appointments cannot be re-scheduled until outstanding fees for missed appointments are paid.

FLEXIBLE SIGMOIDOSCOPY PREPARATION

THE DAY BEFORE YOUR PROCEDURE:

- Eat your regular supper. After supper, you may only have clear fluids.
- Examples of clear liquids: water, apple juice, white grape juice, vitamin water, soda, black tea or coffee (no milk or cream), clear broth, jello, Gatorade

THE MORNING OF YOUR PROCEDURE:

- 1 hour before you come to the hospital:
 - Administer the 2 enemas (follow instructions on package). Be sure to allow the first enema to take effect (~30 minutes) prior to administering the second one.
- NO solid food; you may drink clear liquids only.
- If you are having sedation:
 - You may drink clear fluids up to 4 hours prior to your appointment. Then, make sure to have nothing by mouth (no solid food or liquids) until after your procedure is done.

AFTER YOUR PROCEDURE:

- You will NOT be fit to operate heavy machinery or drive a car for 24 hours after the procedure (if you received sedation).

SPECIAL CONSIDERATIONS

IF YOU ARE DIABETIC:

- Make sure you check your blood sugar levels frequently the day before and the day of your procedure (i.e. every 4 hrs and before bedtime and upon waking)
- Take a sugary drink immediately if your blood glucose drops below 4
- If you are taking oral medication (metformin, glyburide etc.) only take them in the morning the day before the procedure and resume them only once you are eating solid food at your regular scheduled times the day of the procedure
- Insulins are to be taken at ½ the normal dose during the preparation day and should be omitted on the procedure day

IF YOU ARE ON OZEMPIC OR OTHER GLP-1 AGONIST:

- Please let your surgeon know if you are taking any of the following medications:
 - **Semaglutide (Ozempic, Wegovy)**
 - **Tirzepatide (Mounjaro, Zepbound)**
 - **Dulglutide (Trulicity)**
 - **Liraglutide (Victoza)**
- These medications **MUST** be stopped up to **TWO WEEKS** prior to procedure.
- If you have not adequately held this medication prior to procedure, your procedure will be cancelled, as per hospital policy.

IF YOU ARE ON A BLOOD THINNER:

Please notify your surgeon’s office if you are on a blood thinner, and follow the chart below to decide if and when you need to hold this medication. Please confirm in advance with your cardiologist or family doctor that it is safe to stop your blood thinner prior to procedure.

Blood thinner type	Examples	What to do
Coumadin	Also called warfarin	Stop 5 days prior to procedure
Antiplatelet	Plavix (clopidogrel) or Brillinta (ticagrelor)	Stop 7 days prior to procedure
New oral anticoagulants	Xarelto, Eliquis, Pradaxa, apixaban, rivaroxaban, dabigatran	Stop 2 days prior to procedure
Aspirin	81mg	You may continue

OTHER CONDITIONS

Please let your surgeon know if you have the following conditions ahead of time:

- Inflammatory bowel disease
- Any heart condition – this will let your surgeon determine if you need any special considerations before your procedure
- A pacemaker – make sure you bring your pacemaker ID number with you on the day of the procedure
- Any heart valves for which antibiotics are required before procedures
- History of strokes or mini strokes (TIAs)

Flexible Sigmoidoscopy: Patient Information Sheet

What is a flexible sigmoidoscopy?

A flexible sigmoidoscopy is a medical test that allows a doctor to look inside the lower part of your large intestine (colon). This includes the rectum and the lower portion of the colon (sigmoid colon).

The doctor uses a thin, flexible tube with a small camera and light on the end. The tube is gently passed through the rectum.

Why do I need a flexible sigmoidoscopy?

You may need this test to:

- Investigate rectal bleeding
- Check changes in bowel habits
- Look for inflammation, polyps, or other abnormalities
- Follow up on abnormal test results
- Screen for bowel disease in the lower colon

How do I prepare for the test?

The lower part of your bowel must be clean so the doctor can see clearly.

Preparation usually includes:

- A light diet or clear liquids before the test
- One or more enemas before the procedure
- Adjusting or stopping certain medications if advised

Follow the instructions carefully. If the bowel is not clean, the test may need to be delayed or repeated.

What happens during the procedure?

- You will change into a hospital gown
- You will lie on your side
- The procedure usually takes 10–20 minutes

Air or gas is gently put into the colon to help the doctor see. You may feel pressure, cramping, or the urge to have a bowel movement.

What happens after the procedure?

- You will rest until the medication wears off

- You may feel bloated or pass gas for a short time
- You will need someone to take you home
- You should not drive, drink alcohol or make important decisions for 24 hours

Your doctor may explain the results right away. Biopsy results may take a few days.

What are the risks of a flexible sigmoidoscopy?

A flexible sigmoidoscopy is generally very safe, but all medical procedures have some risks.

Common and mild risks

- Bloating or gas
- Mild cramping or discomfort
- Temporary urge to have a bowel movement

Less common but more serious risks

- **Bleeding:** This may occur if a biopsy is taken or a polyp is removed. It is usually minor.
- **Tear or hole in the bowel (perforation):** Rare, but serious. Surgery may be needed.
- **Infection:** Rare, but possible.

Your doctor believes the benefits of the test are greater than these risks.

When should I seek medical help after the test?

Call your doctor or go to the emergency department if you have:

- Severe or worsening abdominal pain
- Heavy rectal bleeding
- Fever or chills
- Dizziness or fainting

Questions or concerns

If you have questions about the procedure, preparation, or risks, please speak with your doctor or nurse.

This information is meant to help you understand your flexible sigmoidoscopy. It does not replace medical advice from your healthcare provider.

CONSENT TO TREATMENT, OPERATIVE PROCEDURE OR INVESTIGATION

Treatment/Operation/Test: *(Do not use abbreviations – write out in full)* _____
Flexible Sigmoidoscopy

I consent to the proposed operative procedure(s), treatment(s) or test(s) described above.

I confirm that the anticipated nature, benefits, risks and side effects of the above have been explained to me, including the anticipated nature, benefits, risks and side effects of any alternative course(s) of action and likely consequences of not having the treatment/operation/test. I understand that other qualified individuals may assist in the treatment/operation/test, this may include qualified medical learners. Any questions I have asked have been answered to my satisfaction.

Signature of Patient/SDM

PRINT NAME

Date (dd/mm/yyyy)

If signed by SDM, state of relationship to patient

If patient is a U.S. or foreign resident, please complete Jurisdiction of Medical Liability Waiver on the reverse of this form

I have read/interpreted/communicated the above consent to treatment information for the patient/SDM.

Signature of Interpreter (if required)

PRINT INTERPRETER'S NAME

TELEPHONE CONSENT

I confirm that I have explained by telephone to _____ the nature of
Name of Substitute Decision Maker

the stated treatment(s), operative procedure(s), or test(s), the anticipated benefits, material risks, material side effects, any alternative course(s) of action and the likely consequences of not having the treatment/operation/test and have answered all their questions.

Signature of Physician/Proposer of Treatment

PRINT NAME/NAME STAMP

Date (dd/mm/yyyy)

Signature of 3rd Party of Telephone Consent

PRINT NAME

Date (dd/mm/yyyy)

EMERGENCY TREATMENT WITHOUT CONSENT

I am proceeding with the emergency treatment(s) as stated on the reverse of this consent because the patient meets the Conditions for Emergency Treatment without Consent as outlined in **Mackenzie Health's Consent to Treatment Policy** and the **Health Care Consent Act**.

Signature of Physician/Proposer of Treatment

PRINT NAME/NAME STAMP

Date (dd/mm/yyyy)

TO BE COMPLETED BY THE HEALTH PRACTITIONER PROPOSING THE TREATMENT

(N.B. Failure to complete this section of the consent form may result in the withholding of treatment to this patient.)

I confirm that I have explained the nature of the above operative procedure(s), treatment(s) or test(s), the anticipated benefits, material risks, material side effects, any alternative course(s) of action and likely consequences of not having the treatment(s) to the above patient / substitute decision maker and answered all their questions.

Signature of Physician/Proposer of Treatment

PRINT NAME/NAME STAMP

Date (dd/mm/yyyy)



**CONSENT TO TREATMENT, OPERATIVE
PROCEDURE OR INVESTIGATION (Continued)****JURISDICTION OF MEDICAL LIABILITY WAIVER FOR TREATMENT OF U.S. AND OTHER FOREIGN RESIDENTS**

I agree that the relationship between myself and Mackenzie Health, its staff, delegates, physicians and other independent health care practitioners providing medical or other health care and treatment to me shall be governed by and construed in accordance with the laws of the Province of Ontario. I acknowledge that the Courts of the Province of Ontario shall have exclusive jurisdiction to hear any complaint, demand, claim, proceeding or cause of action. I hereby agree that I will commence any such legal proceedings in the Province of Ontario and I hereby submit to the exclusive jurisdiction of the Ontario Courts.

Signature of Patient/SDM_____
PRINT NAME_____
Date (dd/mm/yyyy)

I have read/interpreted/communicated the above information regarding the Jurisdiction of Medical Liability Waiver to the patient/SDM.

Signature of Interpreter (if required)_____
PRINT INTERPRETER'S NAME**BLOOD TRANSFUSION/MANUFACTURED BLOOD PRODUCTS** NOT APPLICABLE **Electronic blood consent obtained for this encounter**

I consent to receive donor blood and/or blood products manufactured from donor blood.

I acknowledge that the benefits and risks of receiving a donated unit of blood, including blood products manufactured from donor blood, have been discussed with me and all questions have been answered to my satisfaction. I have received the "Patient Information on Transfusion" brochure.

Signature of Patient/SDM_____
PRINT NAME_____
Date (dd/mm/yyyy)

If signed by SDM, state relationship to patient

I have read/interpreted/communicated the above information regarding blood and blood products to the patient/SDM.

Signature of Interpreter (if required)_____
PRINT INTERPRETER'S NAME

Health Card Number: _____

Date of Birth: _____

Preoperative Anaesthetic Questionnaire

Part I – For all Surgery Programs Patients
To be completed by patient or family member

Date: _____ (dd/mm/yyyy)

Name: _____

Height: _____ cm ft/in Weight: _____ kg lb

Languages Spoken: _____

Do you need an interpreter to communicate with your care providers? Yes No

1.) List of all operations during which you were given a general or other type of anaesthetic:

a) Within one year _____

b) Over one year _____

2.) Do you or have you been told if you have any of the following? Please answer all questions below.

Anesthesia History	Yes	No	Comments
Provider told you that you are hard to intubate			
Nausea and vomiting following sedation			
Malignant hyperthermia			
Headaches after an epidural or spinal anesthesia treatment			
Remained aware of your surroundings once you were sedated			
Pseudocholinesterase deficiency or succinylcholine sensitivity			
Delayed awakening from anesthesia			
Motion sickness			
Sleep apnea			
Have you ever had a reaction to a local/general anaesthetic? Please describe the reaction.			
Has anyone in your family had a reaction to a local/general anaesthetic? Please describe the reaction they had.			
Is there anything else that you would like to tell your anaesthesiologist?			

3) Do you have any drug allergies: Yes No If yes, please fill in the information below.

Drugs	Type of Reaction	Drugs	Type of Reaction

4.) Are you allergic to LATEX? Yes No Don't know (nurse to confirm)

5.) List of any other non-drug allergies (e.g. Grass, Pollen) _____

6.) List of your medications including nonprescription or herbal remedies:

Medication	How much are you taking	How often?	Last Taken (date/time)	



Preoperative Anaesthetic Questionnaire

7.) Are you on blood-thinning medications (prescribed or natural)? If yes, please indicate which medications.

Yes No (If yes, list the medication and state when stopped) _____

8.) Do you smoke or have you ever smoked? Yes No

If yes, state amount of cigarettes/cigar you smoke per day _____ and for how many years _____

If you stopped, when? _____

9.) Have you ever, or do you currently use nicotine e-cigarettes? Note that cannabinoid vaping will be asked in the Marijuana/Cannabinoids section. Yes No

- How often are you using e-cigarettes? (i.e. daily weekly _____
- How many times do you refill your vape per week? _____
- What type of substances do you use? (i.e. Nicotine Flavour) _____
- If you stopped, when? _____

10.) Do you use any recreational drugs? Yes No

- Have you ever, or do you currently use marijuana or cannabinoids? Yes No
 - How often are you using marijuana/cannabinoids? _____
 - What method(s) do you use? _____
 - What substances do you use? THC CBD
 - If you use any other substances, please state them. (i.e. cocaine, heroin, fentanyl) _____
 - Describe, on average, how much you use weekly? _____
- Comments _____

11.) Do you or did you drink alcohol/beer daily? Yes No If yes, state the amount per day _____

If you stopped, when? _____

12.) Do you have any loose, capped or false teeth? If yes, check which and state which tooth (teeth)

loose capped false teeth Other _____

13.) Have you ever been diagnosed with any of the following condition?

***** **Please answer every question listed below.**

Condition	Yes	No	Don't know	Comments (for example when were you diagnosed)
Chronic bronchitis				
Pneumonia				
Shortness of breath				
Asthma				
COPD/Emphysema				
Any other conditions that affect your breathing?				
Frequent headaches				
Migraines				
Dizziness				
Stroke				Residual deficits? Yes <input type="checkbox"/> No <input type="checkbox"/>
Seizures				How often? _____
Anxiety				
Any other conditions that affect your nervous system?				
Chronic back pain				
Chronic neck pain				
Arthritis				
Temporomandibular Joint Syndrome (TMJ)				
Any other conditions that affect your bones?				
Any other conditions that affect your muscles?				

Preoperative Anaesthetic Questionnaire

Condition	Yes	No	Don't know	Comments (for example when were you diagnosed)
Anemia				
Thalassemia				
Sickle cell				Disease <input type="checkbox"/> Carrier <input type="checkbox"/>
Chest pain (angina)				
High blood pressure				
Heart disease				
Heart attack				
Heart Failure				
Irregular heart beat				
Heart murmur				
Do you have a pacemaker?				
Blood clot				Leg <input type="checkbox"/> Long <input type="checkbox"/>
Blood clot in lungs				
Bleeding tendency				
Past blood transfusion?				If so, any reaction? Yes <input type="checkbox"/> No <input type="checkbox"/>
Hiatal hernia				
Peptic ulcer				
Heart burn/acid reflux/GERD				
Crohn's / Colitis/ IBS				
Hepatitis				A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>
Liver problems				
Diabetes				Insulin <input type="checkbox"/> Pill <input type="checkbox"/> Diet <input type="checkbox"/>
Thyroid condition				
Kidney failure				
Dialysis treatment				Hemodialysis <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/>
Any other conditions that affect your bladder?				
Any other conditions that affect your kidneys?				
HIV/AIDS				
Tuberculosis				
Cancer – Where? _____				Chemotherapy <input type="checkbox"/> Radiation <input type="checkbox"/>
Are you pregnant?				How many weeks? _____
Other				

14.) Are you currently being cared for by any specialists? (i.e., endocrinologist, cardiologist, etc.). If yes, please state the specialist's name, specialty and contact information.

Specialist Name: _____ Specialty: _____ Telephone: _____
 Specialist Name: _____ Specialty: _____ Telephone: _____
 Specialist Name: _____ Specialty: _____ Telephone: _____

**15.) Have you ever been on Isolation precautions when in hospital? Yes No If yes, when _____
 What were the infections? (i.e., MRSA, VRE) _____**

16.) If your life is in danger because of severe blood loss, will you accept a transfusion of blood, its components or products? Yes No If the answer is "No", please tell your surgeon **before the day of surgery.**

**17.) If you are having surgery today, please state what time you last ate any food or drank any fluids, including water?
Food: Time _____ Date _____ (dd/mm/yyyy) **Drink:** Time _____ Date: _____ (dd/mm/yyyy)**

18.) Has someone assisted with completing with this form? Yes No

Name: _____ Telephone Number: _____
 (Name of person completing the form)

Signed: _____ Date: _____ Relationship to patient: _____
 (Signature of person completing the form) (dd/mm/yyyy) (if applicable)