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Informed Decision-Making Form

Your provider has recommended that you have a Colorectal Cancer Screening. Screening is the process of looking for cancer in people who have no symptoms. Several tests can be used to screen for colorectal cancers. Based on your risk factors your provider has recommended the following test:

Colorectal Cancer Screening Test

- Colonoscopy - exam of the inner surface of the colon Decline Initial _____
- Stool Test (e.g. FIT) - an early warning test done at home using stool placed on cards and tested in the lab for abnormalities Decline Initial _____
- Flexible Sigmoidoscopy - exam of the inside of the lower part of the colon Decline Initial _____

What is a Colonoscopy?

A colonoscopy is a medical procedure where a flexible tubular instrument is used to view the lining of the colon and rectum.

What is a Stool Test?

A stool test is a test to look for hidden blood in the stool, which can be an early sign of cancer.

What is a Flexible Sigmoidoscopy?

A flexible sigmoidoscopy is a procedure that allows your doctor to examine the rectum and the lower colon.

What are the benefits of having a colorectal screening test?

Colon cancer is usually a very slow growing cancer. If colon cancer is caught early, a better outcome is expected.

What is the risk?

The test is not 100% accurate.

I agree that I have read this whole document and that I was given the opportunity to discuss the benefits of the recommended care and the risks of not getting the care with my provider who has answered all of my questions.

Even knowing all of this, I have decided at this time not to get the recommended colorectal cancer screening test. I know that my decision not to follow my provider's recommendations may endanger my health or my life.

I know that I may change my decision and have the recommended tests and/or treatments at any time in the future.

I have been given educational information about colorectal cancer screening Initial _____

Date: ____ / ____ / ____ Time: _____ (AM) (PM)

Signature of Patient or Authorized Individual: _____

Relationship of Authorized Individual: _____

Provider's Name: _____

Provider's Signature: _____

Witnessed By: _____

Name of Patient: _____ Date of Birth: ____ / ____ / ____