GASTRO
CENTER OF FLORIDA

Capsule Endoscopy Consent Form

I,_____,CONSENT TO HAVING CAPSULE ENDOSCOPY.

Capsule endoscopy is an endoscopic exam of the small intestine. It is not intended to examine the esophagus, stomach, or colon. It does not replace upper endoscopy or colonoscopy.

I understand that there are risks associated with any examination. The main risks of this procedure are bowel obstruction and aspiration of capsule. Both of these could require further procedures for removal or an operation.

There is a 0%-5% risk that the camera may get lodged behind a stricture, tumor or obstruction in which case surgery may be required to remove the obstruction and the retained camera. If this is the case the obstruction is likely the pathology we were looking for in the first place.

I am aware that I should avoid MRI machines or large magnets during the procedure and until the capsule passes following the exam.

I understand that due to variations in a patient's intestinal motility, the capsule May only image part of the small intestine. It is also possible that due to interference, some images may be lost and this may result in the need to repeat the capsule procedure.

I understand that images and data obtained from my capsule endoscopy may be used, under complete confidentiality and with no patient identification, for educational purposes in future medical studies.

I understand that if my insurance company decides not to pay for this procedure for whatever reason I am financially responsible for the costs of the capsule endoscopy. You will be charged the allowable rate set by your insurance company for the service. This amount may range from $950.00 to $1200.00.

I understand that the retrieval of the capsule is my responsibility and the success of the study relies on the return of the capsule to Gastro Center of Florida for interpretation. Unsuccessful retrieval or accidental disposal of the capsule endoscopy will result in being financially responsible for the cost of the pill cam.

The procedure has explained to me along with the risks, alternatives of diagnosis and treatment, and I have been allowed to ask questions concerning the planned examination.

I authorize Dr. _____ To perform capsule endoscopy.

_____	_____	_____
Patient's Name (please print)	Patient's Signature	Date

_____

Witness Signature