ATHERTON ENDOSCOPY CENTER

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AUTHORIZATION AND INFORMED CONSENT FOR SMALL BOWEL CAPSULE ENDOSCOPY

Explanation

The following information should help you understand the reasons for the procedure and explain the possible risks of the procedure. Capsule endoscopy enables your doctor to examine your entire small intestine. You will swallow a vitamin sized video capsule, which has its own camera and light source. During the 8 hour exam, as the capsule travels through your intestine it sends images to a data recorder you will wear on a waist belt. Afterwards the doctor will view the images on a video monitor. Capsule endoscopy helps your doctor determine the cause for symptoms such as abdominal pain, diarrhea, bleeding or anemia. Capsule Endoscopy is not intended to examine the esophagus, stomach or colon.

Principal Risks and Complications

Although complications may occur, they are rare. Potential risks could be retention of the capsule or bowel obstruction. It is important for you to recognize early signs of possible complications. If you develop a fever after the test, have trouble swallowing, develop increasing chest or abdominal pain you should call your doctor immediately. It is possible that the capsule may only image part of the small intestine; the risk of this increases if you are not prepped (cleaned out) completely. Other risks can include complications resulting from other diseases you may have. **YOU MUST INFORM YOUR DOCTOR OF ALL YOUR MEDICAL PROBLEMS AND ALLERGIES.**

Alternatives to Endoscopy

Other diagnostic or therapeutic procedures, such as medical treatment, traditional endoscopy, x-ray and surgery are available. Another option is to choose no diagnostic studies and/or treatment. Your physician will be happy to discuss the benefits and limitations of these options with you.

Medical Education

I consent to the publication (without name or identifying information) of any photographs taken during my procedure to assist in my care, or for the advancement of medical education.

My Supervising Physician is:

____James Torosis, MD

____Daniel Rengstorff, MD

____Vicky Yang, MD

____Cynthia Leung, MD

____Other _____

I certify that I have been informed of and understand the nature and purpose of the procedure, alternative methods and treatment and the risks involved. The possible complications have been explained to me by my doctor.

I understand that even though the physicians and staff of the Atherton Endoscopy Center respect my right to participate in decisions regarding my healthcare, the policy of the Center is that all patients undergoing endoscopy procedures will be considered eligible for life sustaining treatment, thus we will always attempt to resuscitate a patient and transfer you to an acute care hospital.

I hereby authorize and permit the Atherton Endoscopy Center to perform the above procedure. By my signature below I acknowledge that I have had a chance to ask questions and that I have received all the information that I desire.

Date:_____ Signature:_____

Time:_____ If signed by other than patient, indicate relationship:

Witness:_____ _____

(09/13)