**Capsule Endoscopy Consent**

**I, \_\_\_\_\_\_\_\_\_\_\_\_ (patient or guardian) give consent for Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_ or his/her associates to perform a capsule endoscopy for the purpose of evaluating my intestines**

1. **I understand that this procedure involves ingesting a small capsule. Images are taken by the capsule as it passes through the gastrointestinal tract. These images are recorded so that they can be reviewed by a physician. I understand that there is no sedation required for this procedure**
2. **I understand the reason for the procedure which have been adequately explained to me by my physician. I understand I may call the office where I regularly see my physician with any questions about the preparation of procedure. I have had ample opportunity to add questions before signing this consent.**
3. **RISKS: Possible complications of this procedure include, but are not limited to: aspiration, or passage of the pill into the lungs and non natural excretion. This can occur if the pill gets caught in a narrowing within the gastrointestinal tract. These complications, should they occur, may require surgery, hospitalization, and/ or transfusions.**
4. **I understand that there are no guarantees regarding the results of this procedure. Alternative options as deemed medically relevant have been discussed and may include radiographic imaging tests. I understand that these test have their own limitations and benefits.**
5. **I have read and fully understand this consent form. I understand I should not sign if all of my questions have not been answered to my satisfaction.**

***Patient/Legal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ TIME: \_\_\_\_\_\_\_\_\_\_\_\_***

***Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_***