

Patient MRN: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

## At-Home Capsule Endoscopy Consent Form

---

I CONSENT TO HAVING AT-HOME CAPSULE ENDOSCOPY EXAM.

- I understand that capsule endoscopy is an exam of my small intestine.
- I understand that every capsule endoscopy has some risk.
- I understand that the capsule may get stuck inside my body. If this happens, I may need to have other medical procedures to remove the capsule, such as endoscopic and surgical interventions.
- I understand that when swallowing the capsule, I may choke on it and breathe it into my lungs. I understand that if this happens, my doctor is not physically present and can't help me cough out the capsule.
- I understand that I can choose between swallowing the capsule at my doctor's office and swallowing at home.
- I understand that I should not have an MRI scan until the capsule comes out of my body.
- I understand that I should not fly until the capsule comes out of my body.
- I understand that if it takes too long for the capsule to come out of my body, the exam may be incomplete, and I may need another capsule endoscopy exam.
- I understand that if I choose not to swallow the capsule for any non-medical reason, I need to return the unused capsule, in its original packaging, to my doctor's office. I understand that if I don't return the capsule in \_\_\_\_\_ business days, I will have to pay \$\_\_\_\_\_.
- I understand that pictures of my small intestine and doctor's notes about the pictures may be used to teach other doctors about capsule endoscopy. I understand that if this happens, my identity will be hidden.
- I understand that pictures of my small intestine and doctor's notes about the pictures may be used by the company making the capsule now or any time in the future. The company may use the pictures to make other products. I understand that if this happens, my identity will be hidden.
- My doctor has explained the capsule endoscopy exam to me and the risks of the exam. My doctor has also explained other ways to diagnose and/or monitor my condition.
- My doctor has allowed me to ask questions about the exam and has answered all of my questions.
- I understand that I can choose not to have a capsule endoscopy exam.
- I understand an adult must be nearby when I swallow the capsule to help me if I choke on it.
- I confirm that I have read this consent form and I understand the information in it.
- I consent to this at-home capsule endoscopy exam.

Patient Name (Print) \_\_\_\_\_

Date: \_\_\_\_\_

Patient Signature \_\_\_\_\_

Witness \_\_\_\_\_

Signed in Presence of:  Medical Staff

Other (relationship) \_\_\_\_\_