UPB, Inc Endoscopy Center
760 Parkside Ave
Brooklyn, New York 11226

INFORMED CONSENT FOR CAPSULE ENDOSCOPY

Patient Name: _____ Patient Date of Birth and Age: _____
Procedure Date: _____ Medical Record Number: _____
Physician: _____ Primary Physician: _____

I_____, consent to having CAPSULE ENDOSCOPY

Explanation of procedure: Capsule endoscopy is a new 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 endoscopic examination, including but not limited to **PILL RETENTION** and **BOWEL OBSTRUCTION.** An obstruction may require an endoscopy procedure or immediate surgery.

I am aware that I should avoid MRI machines during the procedure and until I confirm 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, for educational purposes in future medical studies.

Dr._____has explained the procedure and its risks to me, along with 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/Guardian: _____
(Please print)

Patient/Guardian signature: _____

Witness: _____

Date: _____