

# Capsule Endoscopy Consent

I authorize the provider selected below and the assistant(s) selected by the provider to perform the following: Capsule Endoscopy.

- Ravi Mallavarapu, MD
- Srinivas Kalala, MD
- Moaz Sial, MD
- Mary Nading, PA
- Barbara Burkle, ARNP
- Tracy Elliott, ARNP
- Kelli DeSerano, ARNP

**Lay Terminology:** Capsule endoscopy helps us evaluate your small intestine. It is performed by swallowing a small disposable video camera contained in a capsule. This capsule will naturally move through the digestive tract, taking color images as it moves through.

I understand that there are risks associated with any endoscopic examination, such as bowel obstruction. I understand that a bowel obstruction may require immediate surgery.

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

I understand that due to variations in a patient’s 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.

My provider 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.

\_\_\_\_\_  
Patient/Patient Authorized Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date