GI Excellence, Inc.

Gastroenterology Associates

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General Gastroenterology

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TEMECULA
31515 Rancho Pueblo Rd. · Suite 202 · Temecula, CA 92592 · (951) 383-6001
(By appt.)

INFORMED CONSENT FOR VIDEO CAPSULE ENDOSCOPY

Patient Name:_____ Date:_____

DOB:_____

I hereby authorize: ☐ Milan S. Chakrabarty, M.D.
General Gastroenterology

☐ Indraneel Chakrabarty, M.D., M.A.
Advanced & Interventional Gastroenterology

and such assistants as may be selected by him/her to perform these procedures and related procedures. I understand that other staff physicians, as well as physicians in residency and fellowship programs, physician assistants and/or nurse practitioners, and nurses, may also participate in the procedure under the direction of my physician(s).

Hand written changes, cancellations or additions to this form are NOT valid.

I CONSENT TO HAVING CAPSULE ENDOSCOPY:

Capsule endoscopy is an 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, such as BOWEL OBSTRUCTION. An 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 intestinal motility, the capsule may only image part of the small intestine and possible lesions/cancers could be missed. 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.

I am aware that the value of the medical equipment used to conduct the capsule endoscopy exam is $5,665 (Data Recorder and Sensor Array). Failure to return the equipment after the exam will result in the patient being responsible and invoiced for this amount.

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's Name (please print) Patient's Signature Date

In presence of: Spouse _____ Companion _____
Parent _____ Patient Alone _____