DIGESTIVE HEALTH ASSOCIATES, P.C.

CONSENT FOR CAPSULE ENDOSCOPY OF THE SMALL BOWEL

This document helps us inform you about this procedure. Please read it carefully and address any questions or concerns you may have personally with the doctor prior to signing it.

Dr. Patrick D. Gerstenberger, Dr. Steven R. Christensen, or Dr. Stuart B. Saslow and his assistants are authorized to perform:

Capsule Endoscopy - Examine the intestines with a "pill camera." This device is designed to record images of the intestinal tract to allow diagnosis of conditions that cannot be ordinarily diagnosed with routine upper endoscopy, colonoscopy or x-rays.

Alternatives: Alternatives include the use of long oral endoscopes (enteroscopes) or surgery. These alternatives are more invasive than capsule endoscopy and often do not allow as complete an evaluation of the small bowel as provided by capsule endoscopy.

RISKS: Capsule endoscopy is generally safe and well tolerated. In about 1% of cases the capsule will become stuck in a previously unrecognized abnormal intestinal narrowing due to inflammation, or a tumor. When a capsule does become stuck, it may require surgical removal. Capsules are more likely to become stuck in indivuals with known Crohn's disease and a history of chronic nonsteroidal anti-inflammatory drug (NSAID) use. Fortunately, the process of a capsule becoming stuck, and the surgery to correct it, provides both a diagnosis and a cure for the problem being evaluated.

PATIENT CONSENT
I have had sufficient opportunity to discuss my condition and treatment with my physicians and/or their associates, and all of my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to base an informed consent to the proposed procedure.

I have read and fully understand this form and I voluntarily authorize and consent to this procedure. I understand that I should not sign this form until all my questions have been answered to my satisfaction and until I understand all the words or terms on this form.

I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedure. I have been advised that the proposed procedure may not improve my condition and may, in fact, worsen it.

X_____ Date: _____ Time: _____
Signature of Patient or Authorized Agent

PHYSICIAN/PROVIDER DECLARATION
I have explained the contents of this document to the patient and have answered all the patient's questions, and to the best of my knowledge, I feel the patient has been adequately informed and has consented.

_____ Date: _____ Time: _____
PA or NP (if applicable)

_____ Date: _____ Time: _____
Physician performing procedure

Revised April 2019