Franklin Medical Group Digestive Disease Center
60 Westwood Ave. Waterbury, CT 06708
203-574-3007 Fax 203-573-1739

Appointment Date:_____ Arrival Time:_____

SMALL BOWEL PILL CAM

DAY BEFORE TEST:

- Drink lots of water 2 days before test.
- Light lunch day before and NO dinner.
- After lunch follow clear liquid diet until 8:00 PM
- No drinking after 8:00 PM the night before your test, unless you need to take medications with a sip of water. You may take your medications up to 2 hours prior to the test with a sip of water, or as advised by the doctor.
- You may have water, ginger ale, thin clear broth (no noodles), green or yellow Jell-O, apple juice or white juices, white Italian ice.
- No solid food
- No coffee or tea
- No iron tablets for 7 days before your test.
- No antacids or Sucralfate (Carafate) for 24 hrs. before your test.
- No smoking for 24 hours before you test
- If you take medications that delay gastric emptying, such as calcium channel blocker (Cardizem, Norvasc, Procardia, Verapamil, etc.) please follow the instructions given to you by the doctor.
- Patients with diabetes may be asked to adjust their Insulin dose.
- You may take Coumadin or Aspirin

DAY OF TEST:

- One Reglan tablet will be called in to your pharmacy. Take this tablet ½ hr. before coming to the office.
- Please wear loose two piece clothing (COTTON SHIRT ONLY)
- No lotions or powders should be placed on your stomach the day of the exam.
- You will be asked to sign a consent form after it has been explained to you by one of the medical assistants.
- The data recorder should not be worn under your clothing. Increased body temperature may cause the data recorder to shut down and cause gaps in the video.
- You may resume your medications 4 hrs. after swallowing the capsule, or as directed by the doctor.

The above information has all been explained to me and I have been allowed to ask questions. I have reviewed the above medical information on the intake form and it is correct as written.

PRINT PATIENT NAME:_____

PATIENT SIGNATURE:_____

WITNESS:_____ DATE:_____

AFTER EQUIPMENT HAS BEEN REMOVED:

Diet: There are no dietary restrictions.

Activities: Following the exam, you may resume normal activities.

Medications: Resume all medications immediately after the capsule.

Further Testing: Avoid MRI until the capsule passes completely through your GI tract, or for 30 days. The capsule will pass naturally in about 24 hours but most likely you will be unaware of its passage.

Staff Initials:_____

Patient Signature:_____Date:_____

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PLEASE BRING THIS CONSENT FORM WITH YOU THE DAY OF THE PROCEDURE.

Patient name: _____Date of exam:_____

CONSENT FOR SB CAPSULE ENDOSCOPY

I consent to having a capsule endoscopy, which is a non-invasive and ambulatory procedure that permits visualization of the patient's GI tract, especially the small intestine. It does not replace an upper endoscopy or colonoscopy. I understand that there are risks associated with any endoscopic exam, such as bowel obstruction. I would contact my doctor immediately at **203-574-3007** if I were to suffer from any abdominal pain, nausea or vomiting. An obstruction may require immediate surgery. If the capsule gets stuck when swallowing, I may need to have it endoscopically inserted.

I am aware that I should avoid MRI machine, x-rays and radio transmitters during the procedure and until the passage of my capsule.

I do understand and have complied with all of the pre-procedure instructions.

I understand that I will not disconnect the equipment or remove the belt during that time period, since the data recorder is actually a small computer and should be treated very carefully. I will avoid sudden movements and will not bang the data recorder.

I understand images and data from the endoscopy may be used under complete confidentiality for educational purposes and future medical studies.

I understand the possibility of surgery may be needed if the capsule is not naturally excreted.

Dr._____, or his trained office representative, has explained the procedure and its risks, as well as the alternatives of diagnosis and treatment, and I have been allowed to ask questions concerning the planned examination.

I authorize Dr._____ and his staff to prepare, instruct and guide me in the ingestion of the capsule. I understand that Dr._____ will be performing the reading of the data to interpret the capsule endoscopy.

Print Patient Name:_____ Date:_____

Patient Signiture:_____

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SUMMARY OF NOTICE OF PRIVACY PRACTICES

By Law, we are required to provide you with our Notice of Privacy Practices. This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to request confidential communications.
5. The right to a report of disclosures of your information.
6. The right to a paper copy of this notice.

Please be advised that we may:

1. Call your name when the doctor is ready to see you.
2. Leave test results or messages on your answering machine.
3. Take your charts out of the office for dictation, review, or to see you in our satellite office.
4. Call your place of employment and ask to speak with you.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally received a copy of the DIGESTIVE DISEASE CENTER OF CT'S Notice of Privacy Policies on the date below.

Signature:_____ Date:_____

Patient (print)_____

Information about Agent (attach appropriate documentation):

Agent:_____

Title:_____

I grant permission to DIGESTIVE DISEASE CENTER OF CT to share my Protected Health Information with the following individuals:

Name:_____Phone#_____Relationship to Patient_____

Name:_____Phone#_____Relationship to Patient_____

Name:_____Phone#_____Relationship to Patient_____

Signature of Patient:_____ **Date:**_____

FRANKLIN MEDICAL GROUP, P.C.
DIGESTIVE DISEASE CENTER

(PRINT) NAME:_____DOB:_____

E-MAIL ADDRESS:_____

Ethnicity:

☐ Hispanic or Latino

☐ Not Hispanic or Latino

Race:

☐ White

☐ Black or African American

☐ Asian

☐ American Indian or Alaska Native

☐ Native Hawaiian or Pacific Islander

☐ Unknown

☐ Hispanic

☐ Mixed Racial Heritage (two or more race)

Signature:_____Date:_____