ADVANCED GASTROENTEROLOGY OF SOUTH FLORIDA, PA
Karthik Mohan, DO
Board Certified Internal Medicine
Board Certified Gastroenterology
Palmetto Medical Plaza
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Phone (305) 556-3727 Fax (305) 556-3711

Informed Consent for Capsule Endoscopy

Name: _____ Procedure Date: _____ Time: _____

1. I, _____ (patient or guardian) give consent for Dr. Karthik Mohan or his/her associates to perform a Capsule Endoscopy for the purposes of evaluating my small intestines.

2. I understand this procedure involves ingesting a small capsule after being attached to a monitor. Images are taken by the capsule as it passes through the gastrointestinal tract. These images are digitally transmitted to a recording device
which then a physician can review. I understand that there is no sedation required for this procedure.

3. I understand the reasons for the procedure which have been adequately explained to me by my physician. I understand I may call the office where I regularly see my physician with any questions about the preparation or procedure. I have had many opportunities to ask questions before signing this consent.

4. **RISKS**: Possible complications of this procedure include, but are not limited to: aspiration, or passage of pill into the lungs, and bowel obstruction. This can occur if the pill gets caught in a narrowing within the gastrointestinal tract. These complications, should they occur, may require surgery, hospitalization, and/or transfusions.

5. I understand there are no guarantees regarding the results of this procedure. Alternative options as deemed medically relevant have been discussed and may include radiological imaging tests. I understand that these tests have their own limitations and benefits.

6. I have read and fully understand this consent form. I understand I should not sign if all of my questions have not been answered to my satisfaction or if I do not understand any of the words or terms used in this form.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED PROCEDURE OR TREATMENT, ASK YOUR PHYSICIAN NOW, BEFORE SIGNING THIS CONSENT FORM. DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.

Signature _____ Date _____

Witness _____ Date _____