Patient MRN:_____ **Patient DOB:** _____

CapsoCam Plus® Capsule Endoscopy Procedure Consent Form

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 additional medical intervention including immediate surgery.

— I am aware that I should avoid MRI examinations until the capsule passes through the system and is excreted and retrieved.

— I understand that due to variations in a body's intestinal motility, the capsule may only image part of the small intestine 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 such as a reference library of images, in future medical studies, and in publications that may include pictures from capsule endoscopy tests without identifying me.

— I further understand my images and data may also be used by the manufacturer of the capsule for improving the capsule images in future designs and for adding new use for the capsule. (Example making a capsule that records images in other areas of the gastrointestinal tract.) The images and data used by the manufacturer for these activities will have all identity removed and will be stored in a secure location. Only select members of the manufacturer's clinical and technical teams will have access to these images.

— My physician 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 certify that I have read the above consent form, understand the information regarding the capsule endoscopy procedure and do hereby consent to this procedure.

Patient Name (Please Print)_____ Date: _____

Patient Signature:_____ Witness:_____

Signed in presence of:

☐ Medical Staff ☐ Spouse

☐ Parent ☐ Family Member

☐ Companion

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