BRONSON	Affix Patient Label
	Patient Name: Date of Birth:

Informed Consent Procedure Capsule Endoscopy For PEDS Only

This information is given to you so that you can make an informed decision about your child having a **Capsule Endoscopy.**

A **Capsule Endoscopy** uses a small pill sized video camera to take pictures of your intestines. You swallow a pill sized camera and it takes pictures until it is passed when you have a bowel movement.

Reason and Purpose of the Procedure
The purpose of the procedure is to look at your child's small intestine for bleeding, inflammatory problems, cancer, and small growths (polyps).

Benefits of this Procedure
Your child might receive the following benefits. Your doctor cannot promise your child will receive any of these benefits. Only you can decide if the benefits for your child are worth the risks.

- The doctor may be able to diagnose and treat a specific condition.
- Early detection of cancer.
- Find sources of bleeding.

Risks of Procedure
No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

- Bowel blockage. This is rare but may need surgery.
- The capsule may only see part of the small intestine because of differences in patients' intestinal tracts.
- The capsule may not come out (this is rare but may require surgery).

Your child should avoid MRI machines until the capsule passes following the exam.

Risks Specific to Your Child

- _____
- _____
- _____
- _____

Alternatives Treatment
Other choices:

- Xrays, CT or MRI of small bowel.
- Do nothing. You can decide not to have the procedure.

If You Choose not to Have this Treatment

- The doctor may miss an important abnormality in your child's small intestine.

General Information

- During this procedure, the doctor may need to perform more or different procedures than I agreed to.
- Tissues or organs taken from my child's body and may be tested. They may be kept for research or teaching. I agree hospital may discard these in a proper way.
- Students, technical sales people and other staff may be present during the procedure. My child's doctor will

supervise them.

- Pictures and videos may be done during the procedure. These may be added to my medical record. These may be published for teaching purposes. My child's identity will be protected.

By signing this form I agree

- I have read this form or had it explained to me in words I can understand. I understand its contents.
- I have had time to speak with my child's doctor. My questions have been answered.
- I want my child to have this procedure**: Capsule Endoscopy.**
- I understand that my child's doctor may ask another doctor with the same qualifications to do this procedure.
- I understand that other doctors, including medical residents or other staff may help with surgery. The tasks will be based on their skill level. My doctor will supervise them.

Provider: This patient may require a type and screen or type and cross prior to surgery. IF so, please obtain consent for blood/product.

Patient Signature_____Date:_____Time:_____

Relationship: □Patient/Parent of Minor □Closest relative (relationship)_____ □Guardian

Interpreter's Statement: I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.

Interpreter:_____Date_____Time_____

Interpreter (if applicable)

For Provider Use ONLY:

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Provider signature:_____ Date:_____ Time:_____

Teach Back

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention, I have answered questions, and patient has agreed to procedure.

Patient shows understanding by stating in his or her own words:

____ Reason(s) for the treatment/procedure: _____

____ Area(s) of the body that will be affected: _____

____ Benefit(s) of the procedure: _____

____ Risk(s) of the procedure: _____

____ Alternative(s) to the procedure: _____

OR

____ Patient elects not to proceed: _____Date:_____ Time:_____

(patient/parent signature)

Validated/Witness:_____Date:_____Time:_____