

**AUTHORIZATION FOR ADMINISTRATION OF ANESTHESIA  
AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES**

The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks, and potential benefits as well as the possibility of complications, recuperation, likelihood of success, and the possible results of non-treatment have been fully explained to me. I understand the nature of the operation or procedure to be:

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**Capsule Endoscopy - An Endoscopic Exam of the Small Intestine**

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Description of operation or procedure in layman's language. Include surgical site. Do not abbreviate.

Written informed consent must be obtained every time a procedure is performed unless the procedure consists of a course of continuous and ongoing regularly scheduled treatments (e.g. chemotherapy, electro convulsion therapy, injections, and IV therapy). In such cases (as long as there is no change in the nature of recommended therapy or other change in circumstances), informed consent need only be obtained once at the outset of the course of treatment.

John Stagias, MD

I request the performance of the above-named operation to be done by Dr. \_\_\_\_\_ or designee and of such additional operations or procedure(s) as are found to be necessary or desirable for my best medical care in the judgment of the primary surgeon.

I have been informed of the benefits and my doctor has explained the potential risks specific to the procedure described above. I have been informed that there are risks attendant to the performance of any surgical procedure including, but not limited to infection, bleeding, and injury to major organs, injury to blood vessels and nerves, and even death. My doctor has discussed his/her experience and success rate with this operation/procedure. I acknowledge that no guarantees have been made to me concerning the results of this operation or procedure.

I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of Harrington Memorial Hospital.

At the discretion of the attending surgeon, I consent to the taking of photographs for documentation or for use in advancing medical education.

Exceptions to surgery, anesthesia or photographs, if any, are: \_\_\_\_\_  
If "None" state so.

I request that the authorities of Harrington Memorial Hospital dispose of any removed tissue or parts only after appropriate pathological examination, except in the case of fetal death when I will be asked to sign a form specific to the disposition of the remains of my pregnancy.

I have been given the opportunity to ask questions relevant to my treatment. All of my questions have been answered to my satisfaction and I wish to proceed with the recommended surgical procedure.

Date: \_\_\_\_\_ Patient's signature: \_\_\_\_\_

Witness: \_\_\_\_\_

I have informed this patient, or their authorized representative, the nature of the proposed procedure(s), attendant risks and expected results.

Date: \_\_\_\_\_ Physician's signature: \_\_\_\_\_

**Authorized individual/legal guardian**

The following is to be completed by the authorized individual or legal guardian when patient is a minor or patient is unable to give consent.

I, \_\_\_\_\_, authorized individual or legal guardian of \_\_\_\_\_, understand the nature of the proposed procedure(s), attendant risks, and the expected results and hereby request such procedure(s) be performed.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of authorized individual or legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

CLEAR LIQUID DIET  
NO ALCOHOLIC BEVERAGES

**\*\*No red or purple colored items\*\***

- Water
- Tea
- Plain coffee (NO milk or Creamora)
- Clear juices such as apple or white grape
- Lemonade from powdered mix
- Fruit-flavored drinks such as Kool-Aid, Crystal Light, etc.
- Clear carbonated beverages/soda
- Sports drinks such as Gatorade, All-Sport, Powerade, etc.
- Fat free broth/bouillon, consommé
- Plain/flavored gelatins
- Fruit ices/Italian ices
- Water-based Sorbet or sherbert

- Popsicles (without milk or added fruit pieces)
- Honey
- Sugar
- Hard candy
- Commercial clear liquid nutritional supplements such as: Enlive (apple or peach flavors only); Carnation Instant Breakfast Juice Drink (orange only—Not regular Carnation Instant Breakfast)

**CLEAR LIQUID DRINK RECIPIES:**

High Protein Fruit Drink

- 8 oz Commercial clear nutritional drink (listed as above)
- ½ cup sorbet
- 6 ounces ginger ale
- Mix all ingredients & blend until smooth.

Fruit Fizz

- 1 cup clear fruit juice from clear liquid list
- ½ cup sparkling water
- ½ cup ice
- Blend ice & juice until slushy. Pour into glass & add sparkling water.

Frozen Fruit Slush

- 1-6 oz can frozen clear juice concentrate
- 4 tbsp sugar
- 3 cups crushed ice
- Mix all ingredients & blend until smooth

Lemon Lime Slushie

- Juice from two limes
- Juice from one lemon
- 1 cup sparkling water
- 1 cup ice
- 4 tsp sugar or to taste

Blend ice & juice until slushy. Pour in glass & add sparkling water

Home-made ice pops can also be made using fruit juice, a sports drink or other favorite clear liquid from above list.

**\*\*No red or purple colored items\*\***

7. **Do not disconnect the equipment or completely remove the DataRecorder** at any time during the procedure.
8. **Treat the DataRecorder carefully.** Avoid sudden movements and banging of the DataRecorder.

**After Completing SB Capsule Endoscopy**

**Return to the doctor's office at the scheduled time** to have the equipment removed.

**Or:** If instructed to remove the equipment at the end of the capsule endoscopy procedure, do the following:

1. Remove the SensorBelt and the DataRecorder and keep in a safe place.
  2. Return all the equipment to your doctor's office as soon as possible. Handle the DataRecorder and other equipment carefully without exposing them to shock, vibration or direct sunlight.
- ⓘ *If you are not sure that the capsule has passed out of your body and you develop unexplained nausea, abdominal pain or vomiting, contact your doctor for evaluation.*
- ⓘ *Undergoing an MRI while the PillCam capsule is inside your body may result in damage to your intestinal tract or abdominal cavity. If you are not certain the capsule is out of your body, contact your physician for evaluation and possible abdominal X-ray before undergoing an MRI examination.*

**Capsule Endoscopy Event Form**

<b>Patient Name:</b>		<b>ID No:</b>
<b>Time</b>	<b>Event (eating, drinking, activity and unusual sensations)</b>	
	PillCam capsule ingestion	
<b>Time to return to facility:</b> _____		<b>Special Instructions:</b>
<b>Contact in case of need:</b>		

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## Patient Instructions for PillCam® Small Bowel Capsule Endoscopy With the SensorBelt

Patient: \_\_\_\_\_

Examination Date: \_\_\_\_\_

To ensure the best results for your PillCam capsule endoscopy of the small bowel, follow your doctor's instructions carefully and completely.

### Day Before Capsule Endoscopy

1. Start the prescribed liquid diet after lunch.
2. Do not eat or drink except for necessary medication with a sip of water, 10 hours before your capsule endoscopy.

### Day of Capsule Endoscopy

1. Do not take any medication 2 hours before having the exam.
2. Wear upper garment of thin, natural fiber such as a T-shirt that is long enough to reach at least to hip level and will not ride up above the belt.
3. Arrive for your appointment at the scheduled time: \_\_\_\_\_

### After Swallowing the PillCam SB Capsule

ⓘ The capsule endoscopy procedure will last approximately 8-9 hours. Contact your doctor's office immediately if you suffer from any abdominal pain, nausea or vomiting during the procedure.

1. You may drink colorless liquids starting 2 hours after swallowing the PillCam SB capsule.
2. You may have a light snack 4 hours after ingestion. After the examination is completed, you may return to your normal diet.
3. Be sure the SensorBelt is tight at the waist. Do not attach anything to it.
4. Check the blue flashing DataRecorder light every 15 minutes to be sure it is blinking twice per second. If it stops blinking or changes color, note the time and contact your doctor.
5. Use the supplied *Capsule Endoscopy Event Form*, to note the time of any event such as eating, drinking or a change in your activity. Return the completed *Event Form* to your doctor at the time you return the equipment.
6. Avoid strong electromagnetic fields such as MRI devices or ham radios after swallowing the capsule and until you pass it in a bowel movement.