Dear _____ Date _____

You have a CAPSULE ENDOSCOPY scheduled for _____.

Please arrive by 7.45am at Dr Dorrington's rooms in Southport.
You will be here for approximately 30 minutes to have the apparatus attached and swallow the capsule. You are to return at 4.30pm on the same day to have the equipment removed. There is a car park underneath the building.

Please find enclosed forms that need to be completed. The ***Capsule Endoscopy Intake Form*** needs to be completed and returned in the envelope provided at least 48 hours prior to your procedure. All other forms can be brought with you on the day of the procedure.

DIETARY INSTRUCTIONS:

The Day before the Procedure:

- Normal diet, including your lunch, up until 1.00pm.
- Clear soups eg. Chicken noodle strained, beef broth etc and clear fluids as listed below, can then be consumed until 7.00pm.
- Between 5:00pm and 6:00pm please mix 1 sachet of Picolax according to packet instructions and consume.
- Clear fluids only including soft drinks, non-red cordials, black tea and coffee are permitted until 10.00pm.
- NIL BY MOUTH FROM 10.00pm.
- Take your medicines in your usual manner unless instructed otherwise by Dr Dorrington

The Day of the Procedure:

- NIL BY MOUTH.

Two hours after ingesting the capsule you may have colourless fluids and your usual morning medication.
You may have a light snack 5 hours after ingestion and then return to your normal diet.
Please wear a cotton singlet or T-shirt, such as Bonds, which covers your hips and which won't ride up. You may wear another loose fitting garment over this. Your upper clothing should be opaque, not sheer. We will go through everything with you on the day of the procedure. Preferably do not take Aspirin, NSAIDs or iron products for 1 week prior to the procedure.
The gap payment of $ _____ is payable on arrival on the day of your procedure. We will accept cash, cheque, Visa, Mastercard or Eftpos. The balance of the account will then be forwarded to Medicare.

If you have any questions, please contact our rooms on the above phone number.

Yours sincerely

Barbara Archer
Practice Manager

CAPSULE ENDOSCOPY INTAKE FORM

Date: ……..

Patient Name: …… DOB: ……

Address: ……

Suburb: ……

Phone: …….. Business: …….. Mobile: ……

1. Do you have a history of bowel obstruction: ……
2. Have you had bowel or intestinal surgery: ……..

   Type of surgery: …….
3. Have you had abdominal radiation therapy: ……
4. Do you take Insulin if so what dose and type of Insulin:……...

   ……
5. Have you taken Aspirin, Anti inflammatory medications or Analgesics other than Paracetamol (Panadol, Panamax) over the last 2 weeks, if so what: ……
   ……
6. Do you have a pacemaker or an implantable defibrillator: ……..
7. Do you have a history of Crohn's disease: ……
8. List all your medications: ……..
   ……
   ……
   ……
   ……...

CONSENT FORM FOR CAPSULE ENDOSCOPY

Capsule Endoscopy is an endoscopic examination of the small intestine. It is not intended to examine the oesophagus, stomach or colon. It does not replace gastroscopy or colonoscopy.

There are risks associated with any endoscopic examination. Complications due to the capsule are unusual. Occasionally a capsule can become stuck at an area of narrowing and if it does not pass it is possible that you may need surgery to remove the capsule.

You should avoid MRI machines during the procedure and until the capsule passes following the examination.

Due to variations in a patient's intestinal motility, the capsule may only image part of the small intestine or even remain in the stomach and not pass into the small intestine. It is also possible that due to interference, some images may be lost and this may result in the need to repeat the capsule endoscopy.

I CONSENT TO HAVING A CAPSULE ENDOSCOPY.

I understand that images and data obtained from my capsule endoscopy may be used, under complete confidentiality, for educational purpose in future medical studies.

I also give Dr Lloyd Dorrington permission to access or obtain relevant medical information from any other health professional or ancillary service provider to assist him with my diagnosis and management.

PATIENT'S NAME: (please print) ……...

PATIENT'S SIGNATURE: ……..

DATE: ……

SIGNATURE WITNESSED BY: ……

WITNESS NAME (please print): ……..