Franklin Medical Group Digestive Disease Center
60 Westwood Ave. Waterbury, CT 06708
203-574-3007 Fax 203-573-1739

Appointment Date:_____ Arrival Time:_____

SMALL BOWEL PILL CAM

DAY BEFORE TEST:

- Eat light lunch at noontime, i.e. soup, sandwich **(nothing red, nothing with red dye**)
- You may have clear liquids until 8:00 pm. No drinking after 8:00 PM the night before the test, unless you need to take medication with a sip of water (**do not take any pills that are red**). You may take your medications up to 2 hrs. prior to the test with sip of water, or as advised by the doctor.
- No coffee or tea.
- No Iron tablets for 5-7 days before your test.
- No antacids or Sucralfate (Carafate) for 24 hrs. before your test.
- No smoking for 24 hrs. before the test.
- If you take medications that delay gastric emptying, such as calcium channel blockers (Cardizem, Norvasc, Procardia, Verapamil, etc) please follow the instructions given to you by the doctor.
- Patients with diabetes may be asked to adjust their Insulin dose.
- You may take Coumadin or Aspirin.

DAY OF TEST:

- One Reglan tablet will be called in to your pharmacy. Take this tablet ½ hr. before coming to the office.
- Please wear loose two piece clothing (COTTON SHIRT ONLY)
- No lotions or powders should be placed on your stomach the day of the exam.
- You will be asked to sign a consent form after it has been explained to you by one of the medical assistants.
- The data recorder should not be worn under your clothing. Increased body temperature may cause the data recorder to shut down and cause gaps in the video.
- You may resume your medications 4 hrs. after swallowing the capsule, or as directed by the doctor.
- **THE PATIENT WILL BE INSTRUCTED (PRIOR TO LEAVING) TO RETURN IN THE AFTERNOON TO HAVE THE EQUIPTMENT REMOVED.**

After Equipment Has Been Removed:

- There are no dietary restrictions.
- Following the exam, you may resume all normal activities.
- You may resume all medications immediately after the test.
- Avoid MRI machines for at least 30 days after testing. The capsule will pass within 24 hours.

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SUMMARY OF NOTICE OF PRIVACY PRACTICES

By Law, we are required to provide you with our Notice of Privacy Practices. This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to request confidential communications.
5. The right to a report of disclosures of your information.
6. The right to a paper copy of this notice.

Please be advised that we may:

1. Call your name when the doctor is ready to see you.
2. Leave test results or messages on your answering machine.
3. Take your charts out of the office for dictation, review, or to see you in our satellite office.
4. Call your place of employment and ask to speak with you.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally received a copy of the DIGESTIVE DISEASE CENTER OF CT'S Notice of Privacy Policies on the date below.

Signature:_____ Date:_____

Patient (print)_____

Information about Agent (attach appropriate documentation):

Agent:_____

Title:_____

I grant permission to DIGESTIVE DISEASE CENTER OF CT to share my Protected Health Information with the following individuals:

Name:_____Phone#_____Relationship to Patient_____

Name:_____Phone#_____Relationship to Patient_____

Name:_____Phone#_____Relationship to Patient_____

Signature of Patient:_____ **Date:**_____

FRANKLIN MEDICAL GROUP, P.C.
DIGESTIVE DISEASE CENTER

(PRINT) NAME:_____DOB:_____

E-MAIL ADDRESS:_____

Ethnicity:

☐ Hispanic or Latino

☐ Not Hispanic or Latino

Race:

☐ White

☐ Black or African American

☐ Asian

☐ American Indian or Alaska Native

☐ Native Hawaiian or Pacific Islander

☐ Unknown

☐ Hispanic

☐ Mixed Racial Heritage (two or more race)

Signature:_____Date:_____