MASSACHUSETTS GENERAL HOSPITAL
GASTROENTEROLOGY

Parking Information & Directions

Wang Building, 5th Floor – 15 Parkman Street, Boston, MA

Parking:

Fruit Street Garage –or– Parkman Street Garage
Garages are located off of Cambridge Street

Directions from the garage:

- After parking in the Fruit Street -or- Parkman Street Garage
- Enter through the Main entrance
- Take the **W** elevator to the 5th floor of the Wang Building
- Once you exit the elevator, follow signs for Gastroenterology.

For directions to our locations and more information, please visit the MGH Parking Office:
www.massgeneral.org/visit

Physician: _____ **Phone Number:** 617-724-6038

Patient Name: _____

Date of Procedure: _____ **Time to Arrive:** _____

Location: _____

Pre-Procedure Instructions for Smart Pill Motility Study

Welcome to the MGH GI Motility Unit. We would like to make your stay as pleasant and safe as possible. Please read these instructions carefully before your Smart Pill Study.

- You will be required to wear a data gathering recorder for 3-5 days.
- You will need to return this data recorder to the GI Unit at the completion of this procedure.
- Please plan to spend one to two hours in our unit for your procedure.
- We will do everything possible to avoid a delay in your procedure, but emergencies may interrupt the schedule.

What you need to do BEFORE you arrive for your procedure:

- Call 1-866-211-6588 to update your registration (if not done within 6 months).
- Be sure you have an insurance referral, if required by your insurance company.

Instructions:

1. **ONE WEEK BEFORE YOUR PROCEDURE:** Please stop proton pump inhibitors. This includes but is not limited to omeprazole (Prilosec), lansoprazole (Prevacid), dexlansoprazole (Dexilant), esomeprazole (Nexium), rabeprazole (Aciphex), pantoprazole (Protonix).
2. **THREE DAYS BEFORE YOUR PROCEDURE:** Please stop H2 blockers. This includes but is not limited to cimetidine (Tagament), ranitidine (Zantac), famotidine (Pepcid), or nizatidine (Axid). Please stop antiemetic (anti-nausea) medications unless otherwise instructed by your physician. This includes but is not limited to ondansetron (Zofran), promethazine (Phenergan), prochlorperazine (Compazine).
3. **THREE DAYS BEFORE YOUR PROCEDURE:** Please stop anti-diarrheal agents, laxative and promotility drugs unless otherwise instructed by your physician. This includes but is not limited to loperamide (Immodium), diphenoxylate and atropine (Lomotil), polyethylene glycol (Miralax), senna, milk of magnesia, dulcolax, lubiprostone (Amitiza), linaclotide (Linzess), erythromycin, metoclopramide (Reglan) and domperidone (Motilium).
4. **ONE DAY BEFORE YOUR PROCEDURE:** IF you are diabetic and taking insulin, take only ½ of your regular dose.

If you have questions or problems about the preparation, please call the motility lab at 857-238-3473.

ON THE DAY of your procedure:

1. You cannot have anything by mouth for 6 hours prior to the procedure.
2. Take all of your medications as you would normally, except for the ones listed above.
3. IF you are diabetic and taking insulin, take only ½ of your regular dose.
4. We will give you a nutritional bar to eat during the procedure.
5. If you are allergic to gluten, call the information line at 857-238-3473.
6. You will not be able to eat or drink for 8 hours after the procedure.
7. You may return to work after the procedure.

Please bring these things WITH YOU to your procedure:

1. A list of all of your medications, including the doses.

AFTER your procedure:

2. You may resume H2 blockers and proton pump inhibitors 24 hours after swallowing the capsule.
3. You may return to work the day after the procedure.

If you have questions about your procedure, call the Patient Information Line at 857-238-3473 and leave a message. A registered nurse will return your call.

Massachusetts General Physicians Organization

NON-COVERAGE NOTICE
(Hospital and Professional Services)

Patient's Name: _____MRN#: _____ DOS: _____

Description of non-covered services:

Smart Pill Wireless Capsule

- ❑ Office visit
- ❑ Office service

Smart Pill Wireless Capsule

MGPO Fee	$ 630.00
MGH Fee- Capsule	$ 1575.00
MGH-Procedure	$ 6898.00
TOTAL	**$9103.00**

- ❑ Aetna
- ❑ Blue Cross Blue Shield
- ❑ Cigna
- ❑ Fallon
- ❑ GIC
- ❑ Harvard Pilgrim HealthCare
- ❑ Neighborhood Health Plan
- ❑ Tufts
- ❑ United Health Care
- ❑ Workers Compensation
- ❑ Other_____

Your health insurance plan has established rules for the reimbursement of health care services. The services that you receive as a result of today's visit (see detail above, if applicable) may not meet these coverage requirements for the following reasons:

- ❑ You did not obtain the necessary referral for today's visit and corresponding services (lab tests and/or radiology services, etc.). [WI]
- ❑ We believe that your health insurance plan may not cover the type of services being provided to you as a result of today's visit. [NC]
- ❑ Your provider does not participate with your insurance plan or is out of network. [WI]
- ❑ Your Primary Care Physician (PCP) information provided could not be verified by your insurance plan. [WI]

As a result, we will bill and work with your insurance company to receive payment for the services rendered. However, you may be held responsible for payment if the claim(s) is (are) rejected for any of the reasons stated above.

Your signature below confirms that you have read this notice and understand and accept this responsibility.

Patient Agreement:

I have been notified by my physician or designee that s/he believes that my insurance or worker's compensation plan is likely to deny payment for the services identified above. I understand that I have the right to decide whether to receive these services. I have decided to receive the services, and agree to be personally and fully responsible for payment if my insurance or worker's compensation plan denies payment for one of the reasons stated above.

Signed,

_____ _____

Patient Signature **Date**

Last updated: July 7, 2004
Final - Form located on the PBO Liaison Shared Drive

(WI,NC) Internal Office Use Only

MASSACHUSETTS GENERAL HOSPITAL

CONSENT FOR PROCEDURE

Patient Identification Area
PATIENT MUST BE IDENTIFIED BY
NAME AND MEDICAL RECORD NUMBER

I hereby authorize _____ to perform the following procedure(s)

Procedure SmartPill (wireless motility capsule)

Site: Massachusetts General Hospital If laterality applies: ☐ Right ☐ Left ☐ Both Sides ☒ NA

I have been informed of 1) the potential risks and benefits of the procedure(s); and 2) the risks and benefits of the alternatives, including the consequences of not having the procedure(s).

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the proposed treatment(s) or procedure(s).

Further I am aware that there are possible risks, such as loss of blood, infection or pain that may accompany any surgical, diagnostic or therapeutic procedure. The following additional risks were explained to me:

Capsule endoscopy is a safe procedure that carries few risks for adults or for children who are able to swallow the capsule. In most cases, the capsule leaves your body when you have a bowel movement later in the day or within several days. It does not need to be retrieved.

Occasionally, the capsule can become lodged in the digestive tract. The risk is under 1.5 percent for most people who have capsule endoscopy. The risk may be higher in people diagnosed with Crohn's disease or people who have an intestinal blockage.

If procedural sedation will be used during this procedure, I understand that this sedation has risks. My physician has discussed the use of procedural sedation. The risks include but are not limited to slower breathing and low blood pressure that may require treatment.

I understand that a potential risk or complication of the procedure is the loss of blood. I understand that I may require blood products during the procedure or in the post-procedure period. If I refuse blood products, I will complete a separate release for blood-free treatment form.

I understand that one or more healthcare industry professionals (technical representatives for medical equipment and device companies) or observers may be present during this procedure for advisory or observational purposes only.

The hospital may photograph, videotape, or record my procedure/surgery for educational, research, quality and other healthcare operations purposes. Any information used for these purposes will not identify me.

I understand that blood or other samples removed during this procedure may later be disposed of by Massachusetts General Hospital. These materials also may be used by Massachusetts General Hospital, its partners, or affiliates for research, education and other activities that support Massachusetts General Hospital's mission.

A team of medical professionals will work together to perform my procedure/surgery. The role and involvement of the senior attending in my procedure has been discussed with me, including that he/she may join the procedure after the opening of the surgical site or may leave during the closing of the surgical site, and may need to step away during non-critical portions of the procedure. The roles of additional practitioners involved in the procedure, indicated below, have also been explained to me. I understand that other medical professionals may be involved in the procedure who are not listed below. The name of those practitioners will be shared with me after the procedure.

Role of Practitioner (check all that apply)		Name of Practitioner if known
	Fellow.	
	Resident. Specify Year:	
	Physician Assistant	
	Advanced Practice Nurse	
	Other, please specify:	
	Other, please specify:	

I have had a chance to ask questions about the risks, benefits, side effects, likelihood of achieving the goals of this procedure, and other approaches. All my questions were answered to my satisfaction and I give permission to have the procedure.

			AM PM
Patient/Surrogate Decision Maker Signature	Printed Name if not Patient	Date	Time
Practitioner Obtaining Consent Signature	Printed Name	Date	AM PM Time

Attending Physician/Primary Practitioner Attestation (not required if individual obtained original consent)
I attest that I discussed all relevant aspects of this procedure/surgery, including the indications, risks, and benefits, as compared with alternative approaches with the patient or surrogate decision maker, answered their questions, and provided information regarding other medical professionals who will be present during the surgery.

			AM PM
Attending Signature	Printed Name	Date	Time

If interpreter was used please complete name or number of interpreter: _____

Telephone Consent
Date: _____ Time: _____ AM PM
Reason for Telephone Consent:_____
Surrogate Decision Maker Name:_____
Consent Received by:_____
Consent Witnessed by:_____

Massachusetts General Hospital

DOCTORS' ORDER SHEET

USE BALL POINT PEN

SIGN ALL ORDERS

DATE AND TIME MUST BE INDICATED ON ALL ORDERS

Date:_____

Patient Name:_____

DOB:_____

MRN:_____

Rm#	Wt.

DATE	TIME	MEDICATION ORDERS ONLY-ORDERED BY	DATE	TIME	ALL OTHER ORDERS
		Clear liquids the day before the procedure NPO after midnight Adjust insulin as noted if indicated.			Please perform a SmartPill. Reason/Indication to perform the test: ☐ 1. Obscure gastrointestinal bleeding ☐ 2. Suspected Crohn's disease *(initial evaluation)* ☐ 3. Known Crohn's disease of colon evaluating for small bowel involvement ☐ 4. Surveillance of small bowel mucosa/ monitoring drug effectiveness ☐ 5. Undiagnosed malabsorption syndrome: ☐ Suspected Celiac disease ☐ Other:_____ ☐ 6. Suspected tumor ☐ 7. Suspected tumor or surveillance of Polyposis syndrome _____ ***Ordering physician's signature***
		For suspected Crohn's check 2 symptoms: 1 from column A and 1 from columns B, C, or D			
		Column A ☐ 789.00 Abdominal pain, unspecified ☐ 789.01 Abdominal pain, RUQ ☐ 789.02 Abdominal pain, LUQ ☐ 789.03 Abdominal pain, RL ☐ 789.04 Abdominal pain, LLQ ☐ 787.91 Diarrhea ☐ 783.21 Significant weight loss Column C ☐ 787.0 Nausea & Vomiting ☐ 787.03 Vomiting ☐ 787.02 Nausea alone			Column B ☐ 280.9 Iron deficiency anemia, unspecified ☐ 280.0 Iron deficiency anemia 2ndary to blood loss (Chronic ☐ 790.1 Elevated ESR or CRP ☐ 578.1 Blood in stool, melena ☐ 792.1 Non specific abnormal findings in stool Column D ☐ 578.9 Hemorrhage of GI tract, unspecified ☐ 555.1 Regional enteritis large intestine ☐ 564.1 Irritable bowel syndrome

10353 (9/13)

Last Updated: 4/14

Form: DOS-02