CEDAR VALLEY
Digestive Health Center

# Agile Patency Capsule Record

Patient Name: _____ DOB: _____ MRN#:_____

Indication: _____

Referring Provider: _____ Ordering Provider: _____

## Pre-Procedure

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Pacemaker |
| ☐ | ☐ | Defibrillator |
| ☐ | ☐ | Difficulty Swallowing |
| ☐ | ☐ | MRI Scheduled |

☐ Pre-Capsule Preparation Followed

☐ Contraindications Reviewed

☐ Patient Consent Obtained

## Procedure

Date: _____ Arrival time: _____ NPO: _____

Capsule ingested at: _____

Difficulty ingesting: ☐ Yes ☐ No

☐ Abdominal X-Ray schedule at: _____ on: _____ time: _____

☐ Order given to patient

☐ Order faxed

Nurse signature: _____ Date:_____

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