MY GUT CARE
EXPERTS IN GUT HEALTH, LIVER AND ENDOSCOPY

Head Office: Suite 110, 1808 Logan Road, Upper Mount Gravatt QLD 4122
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Faecal Microbiota Transplant : Consent Form

Medical Record Number (MRN): _____
First Name: _____
Last Name: _____
Address : _____
Date of Birth: _____

Your doctor has recommended the following treatment: Faecal Microbiota Transplantation (FMT) for you.

Doctor Name: Dr Asif Shahzad
Hospital Name & Address: Sunnybank Private Hospital, 245 McCullough Street Sunnybank QLD 4109

I understand the following condition is indicated in my case:

_____

_____

The clinical decision to proceed with BIOMICRA FMT treatment was made jointly by my doctor and I.

As part of the informed consent process, my doctor has explained, and I understand the following:

- The benefit and risk of BIOMICTRA FMT treatment for my condition
- Details of the procedure including:
  - The date of the procedure
  - The number of doses required
  - The expected Procedure timeframe
- The importance of following all directions of the healthcare team during my treatment
- The costs associated with receiving BIOMICTRA FMT treatment

The following risk/complications have been discussed with me:

- All treatments can have side effects. The most common side effects with FMT are minor and temporary, for example abdominal symptoms such as bloating or pain/ discomfort, nausea or vomiting, diarrhea.
- While most side effects are minor and temporary, more serious or rare side effects have been reported, including but not limited to: fever, infection or sepsis, immune-related conditions, relapse of the original condition, and allergic reactions (such as rash, swelling of lips or tongue, or difficulty breathing).

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- I acknowledge that, as with any medical treatment, there may be currently unknown or unforeseen longer-term risks associated with BIOMICRA FMT therapy.
- The doctor has discussed with me to inform the doctor/ healthcare team or emergency department in the nearest hospital (depending on the seriousness of the side effects), if I experience any problems during my treatment.
- The doctor has discussed what is the most appropriate method of BIOMICTRA FMT delivery for my treatment (e.g. colonoscopy or enema or Gastroscopy). I understand that each method of FMT delivery carries its own risks, including rare but serious complications. My doctor has explained which delivery method is appropriate for me and its associated risks.
- Although extremely rare, there have been isolated cases of death associated with FMT procedures globally. I understand that while BIOMICRA FMT donors are extensively screened — including for drug-resistant organisms — no medical treatment is entirely risk-free.

I acknowledge that:

1. The doctor has explained my treatment options.
2. The doctor has explained any significant risks/ problems associated with this procedure specific to me, as well as the likely outcomes if complications arise.
3. I have had the opportunity to ask any questions about the procedure/ BIOMICTRA FMT treatment above, alternative options, possible outcomes, and risks involved with the treatment and I understand that BIOMICTRA FMT treatment may not work.
4. The doctor has discussed with me the costs associated with BIOMICTRA FMT treatment, and I agree to cover the costs prior to the procedure.
5. I have considered and understood all treatment risks, benefits and alternatives and I consent to undergo this procedure.
6. I confirm that I am giving my consent voluntarily, without coercion, and that I have had sufficient time and opportunity to consider the information provided.
7. I understand that I may withdraw my consent at any time prior to the procedure by notifying my doctor or the healthcare team. However, I acknowledge that if I choose to withdraw after treatment preparation has commenced or costs have been incurred (e.g. donor sample preparation, booking fees, clinical time), I may not be eligible for a full refund. Any refunds, if applicable, will be at the discretion of the clinic and subject to administrative and processing fees.
8. I consent to the use of my de-identified health information for quality improvement and research purposes related to FMT therapy, unless I notify the clinic otherwise.

Patient Name: _____ Doctor Name: _____

Patient Signature: _____ Doctor Signature: _____

Date: _____ Date: _____