COLONOSCOPY AND UPPER GI ENDOSCOPY

NAME:________________________________

You are scheduled for **COLONOSCOPY AND UPPER GI ENDOSCOPY** at Northern G.I. Endoscopy on ______________(date). Your procedure is scheduled for ______________but it will be necessary for you to arrive at ___________to allow for our staff to prepare you for the procedure**. Please do not arrive at NGI prior to 7:15 AM as the doors are locked until that time. NGI closes in the afternoon and patients must be picked up no later than 3:30 PM.**

You will be contacted by a staff member of Northern G.I. Endoscopy prior to your procedure to confirm your appointment and answer any questions that you may have. On the day of the exam, please report to Northern G.I. Endoscopy, located directly behind our office at 5 Irongate Center in Glens Falls. There are designated parking spaces for Northern G.I. patients along the side of the building, near the Pine Street entrance. Whenever possible, please leave valuables including personal belongings at home. As well, please remove jewelry, including piercings, and leave at home.

COLONOSCOPY is an examination of the large intestine by means of a flexible tube with a bright light. This flexible tube is called a colonoscope and it relays images from inside your colon to a video screen viewed by the physician. After you have completed your preparation at home, you will come to Northern GI Endoscopy where the test will be explained, and you will be given an opportunity to ask questions prior to signing an informed consent form. After you change into your gown and robe, the nurse will insert a small intravenous catheter into a vein in your arm and tape it in place to administer medication before and during the test, as needed. You will be lying on the cushioned table on your left side.

When you are comfortable, the doctor will examine your rectum, and then insert the lubricated tip of the tube. During this test, some people experience gas-like sensations or cramps. This relates to the insufflation of air necessary for a proper examination. You might also experience the feeling that you need to move your bowels. This is caused by the presence of the tube and the air. If needed, more medication will be administered to keep you comfortable. The examination usually takes approximately twenty minutes.

The instrument is able to suction any leftover laxative solution and the air put into you, as needed for your comfort. It is possible to take biopsies and remove polyps through a channel in the tube and this procedure is painless.

UPPER GI ENDOSCOPY is an examination of your esophagus, stomach and first part of your small intestine, using a flexible tube called an endoscope which has a bright light on it. When you are comfortable, the doctor will put the tip of the small tube in your mouth, toward the back of your tongue, and ask you to swallow. You

will be able to breathe normally, and the nurse will suction any extra saliva or mucus from your mouth during the test, if necessary.

You may feel some fullness or perhaps the need to belch. This is expected and is related to the air used to distend the stomach to see it well. Most patients are comfortable enough to fall asleep during the examination.

When the procedures have been completed, you will be taken to a recovery room where you will rest for a period of time. Then, the intravenous catheter will be removed from your arm and you may use the bathroom and get dressed. The doctor will then explain the results to you and your family. **Patients can expect to be at NGI for 1-1/2 to 2 hours from the time of admission for the procedure to the time of discharge.**

If you must cancel or reschedule the examination, please call 793-5034 at the earliest possible time. There are often significant delays in rescheduling and if there are any questions re: the need to cancel due to sickness or other health issues, it is essential that you contact our office or our physician on call (after hours or on weekends).

PLEASE NOTE:

1. **Please follow instructions "Miralax/Gatorade Preparation for Colonoscopy" on the next "attached" page. This includes instructions regarding oral intake on the day prior and day of procedure.**

2. **Our office will provide you with specific instructions if you are taking any of the following medications:**

    - **Insulin**
    - **Anticoagulant medications (blood thinners) such as warfarin (Coumadin, Jantoven)**
    - **Antiplatelet medications such as Plavix (clopidogrel), Ticlid (ticlodipine)**

3. **If you are a diabetic and taking oral diabetic agents,** please do not take these medications the day before and the day of your procedure.

4. If you are taking steroid medications (e.g. prednisone, Decadron, Medrol), please discuss this with our office prior to your procedure.

5. **Do not take iron supplements or a multivitamin that contains iron for seven (7) days prior to your colonoscopy.**

6. **All other medications may be continued, including aspirin and nonsteroidal anti-inflammatory drugs (NSAIDs e.g. Celebrex, Bextra, Voltaren, Naprosyn, Motrin, Advil, Aleve). If you have any questions regarding your medications, please contact our office.**

7. **Since you will be given intravenous sedation for this examination, you must have a responsible adult drive you home and accompany you into your residence. As well, you must have a responsible adult stay with you for the next 24 hours. You should plan on limiting your activity and resting at home for the remainder of the day. You must not drive a motor vehicle or operate machinery for the next 24 hours. If there is a problem with these arrangements, please inform our office to allow for rescheduling of your procedure. Sedation for your procedure cannot be administered unless these arrangements are completed.**

8. If your insurance plan requires a referral from your primary care physician, please confirm that our office has received a referral to cover this procedure. If your insurance plan requires pre-authorization for this procedure, please confirm that our office has obtained the pre-authorization.

<u>MIRALAX/GATORADE PREPARATION FOR COLONOSCOPY AND UPPER GI ENDOSCOPY #2</u>

(For patients scheduled for procedures 12 noon or later)

You are scheduled for COLONOSCOPY AND UPPER GI ENDOSCOPY at Northern G.I. Endoscopy. You will need to purchase the following laxatives **over the counter** at your local pharmacy:

1. **One** 10 oz. bottle of Magnesium Citrate (if only cherry flavored is available, this is allowed despite the red color). If preferred, **four** tablespoons of Milk of Magnesia or **two** Dulcolax (bisacodyl tablets) may be substituted for the Magnesium Citrate.
2. **One** 238 gram container of MiraLax (powder).

You will also need to purchase a 64 oz. bottle of Gatorade (avoid red, maroon or purple colored Gatorade). If preferred, G2 or Powerade may be substituted. **To ensure that your bowel is cleansed adequately, please follow the instructions below for the MiraLax/Gatorade colonoscopy prep. DO NOT follow the instructions printed on the MiraLax container.**

<u>The Day Before Examination</u>

1. You may have a light breakfast. This includes your choice of either toast, muffin, or bagel, without seeds or nuts. Do not have fruits or vegetables. Begin clear liquid diet after breakfast. Drink only clear <u>sweetened</u> liquids for lunch and dinner. <u>No solid food, no milk or milk products allowed.</u>

<u>The Day of Examination</u>

1. Five (5) hours prior to leaving for your appointment, drink **one** bottle of Magnesium Citrate, or take **four** tablespoons of Milk of Magnesia, or **two** Dulcolax tablets.
2. Four (4) hours prior to leaving for your appointment, mix the 238 gram bottle of MiraLax in 64 oz. of Gatorade, G2 or Powerade. Shake the solution until the MiraLax is dissolved.
3. Drink 1 (one) 8 oz. glass of the MiraLax/Gatorade solution every 15 minutes until the solution is gone. (Four 8 oz. glasses in approximately 1hour).
4. Clear liquids and oral medications may be ingested <u>until 3 hours</u> prior to your scheduled procedure time. <u>No solid food, no milk or milk products allowed.</u>
5. Appear for examination as scheduled.

Note: Plan to have a bathroom or commode very accessible.

If you have any questions as you proceed with the laxative preparation for your colonoscopy, please call our office to speak with the physician on call.

CLEAR LIQUID DIET

Only These Liquids Are Allowed:

Soups:	Bouillon, broth (including chicken, turkey, & beef), consommé.
Beverages:	Tea, coffee, decaffeinated coffee, Kool-Aid, carbonated beverages, including sodas (dark colored colas & root beer are allowed), flavored seltzers, Gatorade, Crystal Light.
Juices:	Apple, white grape, grapefruit, lemonade, limeade, and orange juice (juices should have no pulp).
Desserts:	Jell-O, water ices, sorbet, iced popsicles.
Miscellaneous:	Sugar, salt, hard candy.

Note: **Please avoid red, maroon or purple colored liquids, as these can be mistaken for blood during the course of your bowel prep. Please do not add milk or cream to any beverages, including coffee or tea.**

Recipe for High caloric Lemonade (240 calories per 8 ounce cup):

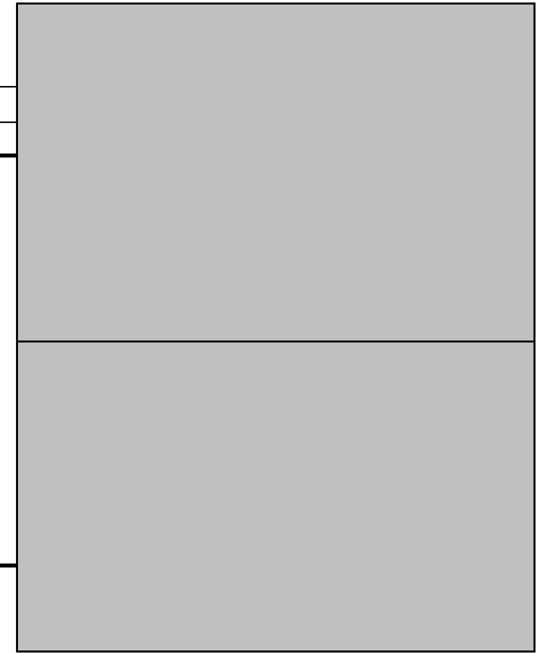
Lemon juice – 2 ounces or ¼ cup
Corn Syrup – 10 to 12 ounces or approximately 1 to 1-1/2 cups
Water to make 1 quart

NORTHERN GI ENDOSCOPY - PRE-ADMISSION HISTORY

▶ PATIENTS PLEASE COMPLETE and BRING TO EXAM ◀

Name: ____________________________________ DOB: __________

Primary Physician: ____________________________________ Height:_________ Weight:__________



ALLERGIES: (list below) ☐**None**

Medications, Food, Latex:____________________________________

Reactions:____________________________________

Anticoagulants/Anti-platelet drugs (Blood Thinners)

Prescribed by:______________________,MD / Reason:______________________________

☐Aspirin __________mg/_______x day / date of last dose____________

☐Coumadin __________mg/_____day _____ every other day / date of last dose___________

☐Plavix (clopidogrel)

☐Ticlid (ticlopidine)

☐Other:

Were you instructed by your doctor to discontinue any of the above medications? ___No ___Yes

If Yes, date of last dose:_____________

MEDICATIONS: (All prescription, vitamins, supplements and over-the-counter medications)

☐ **NONE**

Medication /Strength	Dose	Frequency	Last Dose	Why do you use this medication?

PREVIOUS SURGERIES/HOSPITALIZATIONS:

☐ **NONE**

Date:	Description:

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Please Check Any/All Problems That
YOU PERSONALLY **Have Currently Or**
Have A History Of:

Gastrointestinal ☐ No Problems

Current	History Of	
		Colon Cancer
		Colon Polyps
		Family History Colon Polyps
		Family History Colon Cancer
		Rectal Bleeding
		Black Stools
		Occult(hidden) Blood Stool
		Ulcerative Colitis
		Crohn's Disease
		Excessive Gas
		Diarrhea
		Constipation
		Irritable Bowel Syndrome
		Diverticulosis/itis
		Ostomy
		Reflux/Heartburn
		Difficulty Swallowing
		Barrett's Esophagus
		Ulcerative Colitis
		Nausea
		Vomiting
		Abdominal Pain
		Hiatal Hernia
		Liver Disease
		Hepatitis
		Yellow Jaundice
		Gallbladder Disease
		Other:_______________

Neurological ☐ No Problems

Current	History Of	
		Seizures/Epilepsy
		Migraines
		Psychological or Mental Illness
		Chronic Pain
		Other:_________________

Circulatory ☐ No Problems

Current	History Of	
		Chest Pain
		Palpitations
		High Blood Pressure
		Mitral Valve Prolapse
		Pacemaker
		Heart Valve Replacement
		Heart Attack
		Heart Murmur
		Stroke (TIA,CVA)
		Irregular Heart Beat
		History Rheumatic Fever
		Prolonged Bleeding from Cut
		Coronary Artery Bypass Surgery
		Coronary Artery Stent Placement
		DVT/PE(Deep Vein Thrombosis/Pulmonary Embolus)"Blood Clots"
		Angioplasty
		Other:_________________

Respiratory ☐ No Problems

Current	History Of	
		Cough
		Smoker
		Asthma
		Tuberculosis
		Wheezing
		Shortness of Breath
		Pneumonia
		Emphysema
		Sleep Apnea
		Inhaler (with you __Yes __No)
		Skin Test Date:___________ __Positive __Negative
		Other:__________________

Metabolic/Endocrine ☐ No Problems

Current	History Of	
		Diabetes __Diet Controlled __Insulin
		Low Blood Sugar
		Thyroid Disease
		Other:_______________

Miscellaneous ☐ No Problems

Current	History Of	
		Arthritis
		Kidney Disease/Renal Failure
		Joint Replacement (hip, knee)
		Radiation Therapy
		Bleeding Problems/Anemia
		Previous Blood Transfusions
		Hernia
		Glaucoma
		Possibly Pregnant Last Period Date:___________
		Dislocated Jaw
		Last Prostate Exam:_________

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DO YOU HAVE ADVANCE DIRECTIVES?
Living Will:__No __Yes(Please bring a copy)
Health Care Proxy: __No __Yes (Please bring a copy)

IMPLANTS:
I.e.-eye, hip, pacemaker, access devices, pain control devices, internal defibrillator
__No __Yes If yes, describe implant and its location:________________________________
Dentures:__No __Yes __Upper __Lower
Glasses:__No __Yes
Hearing Aid(s):__No __Yes __Left __Right

PSYCHOSOCIAL:
Are there spiritual, cultural, special practices or needs that we should be aware of during your care? (e.g. meditation, complementary therapies, sleep pattern, dietary) __No __Yes
If yes,describe:____
Is there any way we can help with these?____
Do you have any concerns related to today's procedure outcome? __No __Yes If yes, please describe:____
Do you smoke?__No __Yes, how much?_______________
Do you drink alcohol?__No __Yes, how much?_________________
Do you drink coffee?__No __Yes, how much?________________
Have you experienced an unintended weight change of more than 10 pounds in the past six months? __No __Yes If yes, how much?___________

ASSESSMENT:
What problem and systems caused you to seek medical help?
____
____
When did it begin?____
Have you had recent tests, x-rays, MRI's, CT scans, or other tests related to today's procedure? __No __Yes
If yes, which tests:____
Where:_________________________________ When:_________________________________
Have you experienced any problems/complications with prior surgeries, related to **anesthetics** or **conscious sedation**? __No __Yes
If yes, describe:____

FUNCTIONAL ASSESSMENT:
Problems with walking, eating, dressing self, bathing, toileting? __No __Yes
Have you had any recent/significant change in swallowing? __No __Yes
Have you had any recent/significant change in caring for yourself or performing your ADL's (i.e. dressing yourself, bathing, toileting)? __No __Yes
Have you lost your ability to walk and/or mobilize yourself? __No __Yes
(If yes is answered to any of the previous questions, notify MD for appropriate Therapy consult)

Patient Signature:_________________________________
RN Review Signature:______________________________

____
Signature of Physician Reviewing/Obtaining History

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STATEMENT OF COMPLIANCE

Since you will be given a sedative for this examination, you must have a responsible adult take you home and accompany you into your residence. As well, you must have a responsible adult stay with you for the next 24 hours. You should plan on limiting your activity and resting at home for the remainder of the day. You must not drive a motor vehicle or operate machinery for the next 24 hours. If there is a problem with these arrangements, please inform this office to allow for rescheduling of your procedure. Sedation for your procedure cannot be administered, and the **PROCEDURE MAY BE CANCELLED** unless these arrangements are complete.

Please state name of the person driving you home:________________________

Responsible adult who will accompany you home:________________________

Responsible adult staying with you for the next 24 hours:___________________

Patient Signature:_______________________________ **Date:**________________

Authorization for Follow Up Communication

I am aware that I will be contacted after my procedure by the Endoscopy Center to follow up on my recovery. Within 3 days after the procedure I would like to be called at this #________________________

If I am unavailable, I give permission to leave a message ☐Yes ☐No

As part of Northern GI's ongoing effort to assure excellent quality care, I understand I will be contacted again approximately 30 days after the procedure to address my overall satisfaction with the experience and assure no complications have arisen.

Patient Signature:_______________________________ **Date:**________________