

UPPER G.I. ENDOSCOPY

NAME: _____

You are scheduled for an **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 your exam, please report directly 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 all jewelry, including piercings, and leave at home.

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 arrive at Northern GI Endoscopy, 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 then lie on the cushioned table on your left side. 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 relates to the insufflation of air necessary for a proper examination. This is normal and most patients are comfortable enough to fall asleep during the examination. The examination usually lasts approximately ten to fifteen minutes.

When the procedure has 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. Do not eat or drink anything or take oral medications after midnight the night before your examination, if scheduled for 10 A.M. or earlier. If scheduled after this time, clear liquids and oral medications may be ingested until 3 hours prior to your scheduled procedure time.**
- 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. 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.**
- 6. 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.**
- 7. 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.**

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 _____

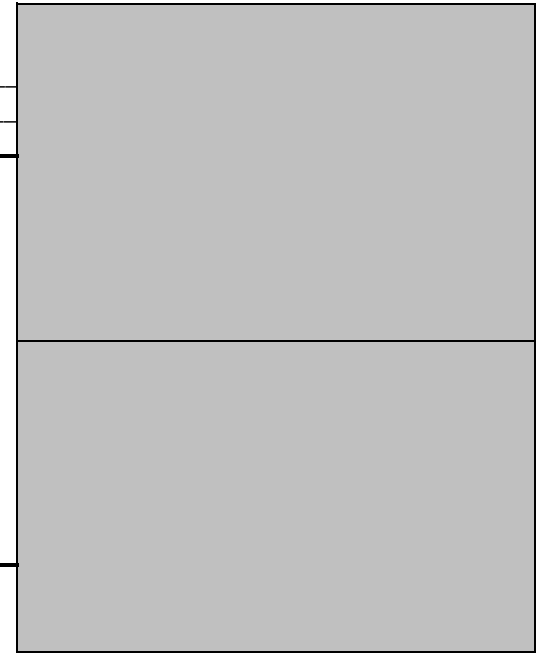
Plavix (clopidogrel)

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
 Have A History Of:

Or

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:_____

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:_____

Metabolic/Endocrine No Problems

Current	History Of	
		Diabetes
		___Diet Controlled ___Insulin
		Low Blood Sugar
		Thyroid Disease
		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:_____

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:_____

Neurological No Problems

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

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

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:** _____