COLONOSCOPY AND UPPER GI ENDOSCOPY

NAME:_____

You are scheduled for **COLONOSCOPY AND UPPER GI ENDOSCOPY** at the Saratoga Surgery Center 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**.**

Patients failing to cancel their colonoscopy and upper GI endoscopy appointment at least 7 days in advance will be billed an administrative fee of $100 by Gastroenterology Associates of Northern N.Y., PC. This fee must be paid in full prior to scheduling future appointments. 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 regarding 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).

The Saratoga Surgery Center staff will be calling to pre-register you. If you have not been contacted by the Saratoga Surgery Center staff within 10 days of your scheduled appointment, please call 693-4401. On the day of your exam, please report to the Saratoga Surgery Center, located on Rte. 50 in Saratoga, approximately 0.6 miles north of Exit 15. Whenever possible, please leave valuables including personal belongings at home. As well, please remove all 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 the GI Center 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 the Saratoga Surgery Center for 2-1/2 to 3 hours from the time of admission for the procedure to the time of discharge.**

PLEASE NOTE:

1. **Please follow instructions "Miralax/Gatorade Preparation for Colonoscopy" on the next "attached" page. This includes instructions regarding dietary restrictions 7 days prior and 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), Pradaxa (dabigatran), Xarelta (rivaroxaban), Eliquis (apixaban), Savaysa (edoxaban)**
    - **Antiplatelet medications such as Plavix (clopidogrel), Brilinta (ticagrelor), Effient (prasugrel)**
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.
9. **The forwarded Endoscopy Pre-Admission History form must be completed prior to presenting for your procedure. Failure to complete this important form may lead to significant delays and/or cancellation of your procedure(s).**
10. **Due to the increasing number of patients with high deductible plans, all deductibles, copays, and coinsurance are due five days prior to your appointment. Payment should be mailed or brought to our office at Five Irongate Center, Glens Falls, New York. If our office does not receive payment within the above timeframe, your procedure will need to be rescheduled.**

MIRALAX/GATORADE PREPARATION FOR COLONOSCOPY AND UPPER GI ENDOSCOPY

You are scheduled for COLONOSCOPY AND UPPER GI ENDOSCOPY at the Saratoga Surgery Center. 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 **four** Dulcolax (bisacodyl tablets) may be substituted for the Magnesium Citrate.
2. **Two** 119 gram containers of MiraLax (powder).

You will also need to purchase **two** 32 oz. bottles of Gatorade (avoid red, blue, green 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.**

Seven (7) days prior to examination – Do not eat high fiber foods such as popcorn, beans, seeds (flax, sunflower, quinoa), multigrain breads, nuts, salad/vegetables, or fresh and dried fruit.

The Day Before Examination

1. Drink only clear, sweetened liquids for breakfast, lunch, and dinner. No solid food, no milk or milk products allowed.
2. At 5:00 p.m. drink **one** bottle of Magnesium Citrate or take **four** tablespoons of Milk of Magnesia or **four** Dulcolax tablets.
3. At 6:00 p.m. mix **one** 119 gram bottle of MiraLax in 32 oz. of Gatorade, G2 or Powerade. Shake the solution until the MiraLax is dissolved.
4. 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 1 hour).
5. Continue drinking clear fluids until bedtime.

The Day of Examination

1. Three (3) hours prior to leaving for your appointment, mix **one** 119 gram bottle of MiraLax in 32 oz. of Gatorade, G2 or Powerade.
2. Drink 1 (one) 8 oz. glass of the MiraLax/Gatorade solution every 15 minutes until the solution is gone. (Four 8 oz. glasses in 1 hour).
3. Clear liquids and oral medications may be ingested until 2 hours prior to your scheduled procedure time. No solid food, no milk or milk products allowed.
4. 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, blue, green or purple colored liquids. Please do not add milk or cream to any beverages, including coffee or tea.

Note: Premoistened bathroom wipes may be used to reduce any anal discomfort during preparation.

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

The Saratoga Hospital

Endoscopy
Pre-Admission History

Patient to Complete and Bring to Exam

Name: _____ DOB: _____
Physician: _____ Primary Care Physician: _____
Height: _____ Weight: _____
Why are you having this exam? _____

Allergies: ☐ No Allergies
Medications, Food, Latex: _____

_____

Reactions: _____

Do you routinely take:
- ☐ Aspirin (last dose: _____)
- ☐ Non-steroidals (Ibuprofen) (last dose: _____)
- ☐ Anticoagulants (blood thinners) (last dose: _____)
- ☐ Antibiotics (within last 3 weeks) (last dose: _____)

Were you instructed by your physician to discontinue any of the above medications? ☐ No ☐ Yes
If Yes, list: _____ When were they discontinued? _____

Medication List: (Please include all vitamins, herbs, and over -the-counter drugs).

Medication/Strength	Dose	Frequency	Last Dose	Why do you use this medication?
☐ NONE				

Previous Surgeries / Hospitalizations:

Date	
	☐ NONE

The Saratoga Hospital

Endoscopy Pre-Admission History

PLEASE CHECK ANY/ALL PROBLEMS THAT *YOU PERSONALLY* HAVE CURRENTLY OR YOU HAVE A HISTORY OF BELOW:

Gastrointestinal

Current/History of: ☐No Problems

		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
		Ulcer
		Nausea
		Vomiting
		Abdominal Pain
		Hiatal Hernia
		Liver Disease
		Hepatitis
		Yellow Jaundice
		Gallbladder Disease
		Other: _____

Respiratory

Current/History of: ☐No Problems

		Cough
		Smoker
		Asthma
		Tuberculosis
		Wheezing
		Shortness of Breath
		Pneumonia
		Emphysema
		Sleep Apnea
		Inhaler (with you: ☐Yes ☐No)
		Skin Test Date: _____ ☐Positive ☐Negative
		Other: _____

Circulatory

Current/History of: ☐No Problems

		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
		Angioplasty
		Other: _____

Metabolic/Endocrine

Current/History of: ☐No Problems

		Diabetes (☐Diet controlled ☐ Insulin)
		Low Blood Sugar
		Thyroid Disease
		Other: _____

Neurological

Current/History of: ☐No Problems

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

Miscellaneous

Current/History of: ☐No Problems

		Arthritis
		Kidney Disease/Renal Failure
		Joint Replacement (i.e. hip, knee)
		Radiation Therapy
		Bleeding Problems/Anemia
		Previous Blood Transfusions
		Hernia
		Glaucoma
		Possibly Pregnant (last period date: _____
		Dislocated Jaw
		Other: _____

The Saratoga Hospital

Endoscopy Pre-Admission History

DO YOU HAVE ADVANCED DIRECTIVES?

Living Will: ☐ No ☐ Yes (please bring a copy)
Healthcare Proxy: ☐ No ☐ Yes (please bring a copy)

IMPLANTS:(i.e. eye, hip, pacemaker, access devices, pain control devices, internal defibrillator (please describe location of all devices) ☐ No ☐ Yes If Yes, please describe: _____
Dentures: ☐ No ☐ Yes If Yes, ☐ Upper ☐ Lower **Glasses:** ☐ No ☐ Yes **Contact Lenses:** ☐ No ☐ Yes
Hearing Impairment: ☐ No ☐ Yes **Hearing Aid(s):** ☐ No ☐ Yes If Yes, ☐ Right ☐ Left

PSYCHOSOCIAL: Are there any 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? ☐ No ☐ Yes If Yes, please describe: _____

Do you have any concerns related to today's procedure/outcome? ☐ No ☐ Yes If Yes, please describe: _____

Do you smoke? ☐ No ☐ Yes If Yes, How much? _____
Do you drink alcohol? ☐ No ☐ Yes If Yes, How much? _____
Do you drink coffee? ☐ No ☐ Yes If Yes, How much? _____
Have you experienced an unintended weight change of more than 10 pounds in the last six months? ☐ No ☐ Yes
If Yes, How much? _____

ASSESSMENT:

What problem and symptom 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, please 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 Physician for appropriate Therapy Consult)

Patient Signature: _____ RN Review Signature: _____

Signature of Physician Reviewing/Obtaining History: _____ Date: _____

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 you procedure cannot be administered, and the PROCEDURE MAY BE CANCELED unless these arrangements are complete.

Please state the 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 cont acted after my procedure by the Saratoga Surgery Center to follow-up on my recovery. Within 3 days after the procedure, I would like to be called at the following number: _____.

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

Patient Signature: _____ Date: _____

There are multiple charges you will incur when having a procedure performed. The physician performing your procedure will have a charge, the facility where you have your procedure performed will have a facility charge and if you have a biopsy taken or polyp removed there will also be a fee for pathology services. Most patients will undergo conscious sedation which is given by our physicians and included in the physician charge, but if you are scheduled for anesthesiologist assisted sedation, there will also be a charge for the anesthesiologist.

The Physicians of Gastroenterology Associates of Northern New York, P.C. participate with the following insurance plans:

Aetna
Blue Shield of Northeastern New York
CDPHP
Emblem Health (GHI)
Empire Blue Cross
Fidelis
Magnacare (Health Republic)
Martins Point
Medicare
MVP
New York State Empire Plan
New York State Medicaid
Shared Health Network

If your insurance plan is not listed above, please call our billing office at 793-5034 to discuss your insurance coverage and financial responsibility.

You will need to contact the facility where you are scheduled for your procedure to discuss whether they participate with your insurance company. They will also be able to answer questions about the pathology services. If you are scheduled for your procedure at Northern GI Endoscopy our billing office can help answer any insurance questions you may have regarding the facility fees or pathology fees.

Our physicians have privileges and perform procedures at Glens Falls Hospital, Saratoga Surgery Center and Northern GI Endoscopy.