

COLONOSCOPY AND UPPER GI ENDOSCOPY

NAME: _____

You are scheduled for **COLONOSCOPY AND UPPER GI ENDOSCOPY** at Northern G.I. Endoscopy 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. **Please do not arrive at NGI prior to 7:00 AM as the doors are locked until that time. Please use 25 Pine Street, Glens Falls, NY, 12801 for GPS directions.**

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).

You will be contacted by a staff member of Northern G.I. Endoscopy Center 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 Center, 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 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 NGI for 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), Xarelto (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 gold colored Northern GI Endoscopy Center 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. Our billing office should be contacted at (518) 793-5034 if you have any questions about your financial responsibility. 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 Northern G.I. Endoscopy 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

Northern GI Endoscopy Center

PATIENT PRE-ADMISSION HISTORY

please complete and bring to appt

Patient Name:

Primary Physician:

Ht:

Wt:

*GRAY AREAS FOR OFFICE USE ONLY

Reason for Visit:

Please list all Allergies (Medications, Food, Latex) and describe reaction :

List ALL medications, vitamins, herbal, over the counter, pumps, patches, inhalers, sprays, ointments.

Medication Name	Dose	Frequency (How Often)	Indication (Reason)	MEDICATION LAST DOSE TAKEN	Resume Medication After Discharge		Special Instructions/ Changes
					YES	NO	
					<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	
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					<input type="checkbox"/>	<input type="checkbox"/>	

Are any of the listed medications ☐ MAOI ☐ Blood thinners ☐ Diabetic Control ☐ NSAID

Medication Verification Source: ☐ Patient ☐ Family ☐ Provided List ☐ History & Physical (PCP) ☐ Other _____

You may resume all medications marked "YES" in table above (column labeled: "Resume Medications After Discharge").

If you have any questions, please contact your referring provider/ primary care physician.

** Your GI Doctor is resuming the start of your medication based on the information provided by you, including the name of the medications, dosages and frequency.

New Medications Prescribed Following Your Endoscopic Procedure at Northern GI Endoscopy Center

Medication	Dose/ Route/ Frequency	Next Dose	Indication

Additional Medications administered at Northern GI Endoscopy Center not listed on Endoscopy Report :

Medication	Dose / Route	Indication

☐ The patient may be discharged

PHYSICIAN SIGNATURE

TIME

RN SIGNATURE / RN SIGNATURE

Please Check Any/All Problems That YOU Have Currently Or Have A PERSONAL History of.

Gastrointestinal ☐ No Problems

Current	History Of
	Colon Cancer
	Colon Polyps
	Family History Colon Cancer
	Family History Colon Polyps
	Hemorrhoids
	Rectal Bleeding
	Black Stools
	Occult(hidden) Blood Stool
	Ulcerative Colitis
	Crohn's Disease
	Excessive Gas
	Diarrhea
	Constipation
	Irritable Bowel Syndrome
	Diverticulosis/itis
	Hernia: Location: _____
	Ostomy
	Reflux/Heartburn
	Difficulty Swallowing
	Barrett's Esophagus
	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
	Numbness
	Weakness Right / Left
	Tremors Right / Left

Circulatory ☐ No Problems

Current	History Of
	Chest Pain
	Low Blood Pressure
	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
	"Blood Clots" DVT/PE (Deep Vein Thrombosis/Pulmonary Embolus)
	Angioplasty
	Atrial Fibrillation
	Palpitations
	Other: _____

Respiratory ☐ No Problems

Current	History Of
	Cough
	Smoker
	Asthma
	Tuberculosis
	Wheezing
	Shortness of Breath
	Pneumonia
	Emphysema / COPD
	Sleep Apnea
	Have you been tested? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Inhaler (with you <input type="checkbox"/> Yes <input type="checkbox"/> No)
	Skin Test \
	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
	Other: _____

Metabolic/Endocrine ☐ No Problems

Current	History Of
	Diabetes
	Oral Agent ___ 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
	Spinal/Back Problems
	Glaucoma
	Possibly Pregnant
	Last Period Date: _____
	Dislocated Jaw
	Last Prostate Exam: _____
	TMJ
	Cancer of any kind: _____

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IMPLANTS: (eye, hip, pacemaker, access devices, pain control devices)

☐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?
(ex: 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 use street drugs? ☐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:

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 (ex: dressing yourself, bathing, toileting)? ☐No ☐Yes

Have you lost your ability to walk and/or mobilize yourself? ☐No ☐Yes

PREVIOUS SURGERIES/ HOSPITALIZATIONS

Description	Date	Location	Doctor

DO YOU HAVE ADVANCE DIRECTIVES? NO [] YES [] IF YES PLEASE BRING A COPY WITH YOU TO YOUR EXAM

I/We understand that it is the policy of this Healthcare Facility to resuscitate all patients that require resuscitation in order to maintain their vital functions, regardless of whether an Advance Directive to the contrary is in place

Patient initials: _____

PATIENT SIGNATURE

RN Signature

MD Signature

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STATEMENT OF COMPLIANCE

If you are requiring a sedative for this examination, **YOU MUST HAVE** a responsible adult (**18yrs or older**) to take you home and stay with you for the **24 hour period after the exam**. Unaccompanied rides via taxis and buses are not permitted. You should plan on limiting your activity and resting at home following your procedure. Following sedation you **MUST NOT** drive a motor vehicle or operate machinery for 24 hours. If you have 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.

Name of Responsible Adult (at least 18yrs old) driving you home/ Relationship to you:

***Please note: We expect the adult driving you home will be present for the post procedure consultation with your doctor.**

Responsible Adult (at least 18yrs old) staying with you for the next 24 hours:

Authorization for Follow Up Communication

I am aware that I will be contacted within 3 days after my procedure to follow up on my recovery. I would like to be called at this phone #

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

As part of NGIEC's ongoing effort to assure excellent quality care, I understand I will receive a survey approximately 30 days after the procedure to address my overall satisfaction with the experience.

I attest that if I have to seek medical care at a hospital for any reason in the 30 day period following the exam, or if I develop complications relating to my procedure. I will notify my doctor at 518-793-5034.

Patient Signature: _____ Date: _____

Revised 08/17

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.