UPPER G.I. ENDOSCOPY

NAME:_____

You are scheduled for an **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 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., P.C. 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 your exam, please report directly 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 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 2 to 3 hours from the time of admission for the procedure to the time of discharge.**

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), 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 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.

8. **The forwarded gold colored Northern GI Endoscopy Center Pre-Admission History form <u>must</u> 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).**

9. **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. <u>If our office does not receive payment within the above timeframe, your procedure will need to be rescheduled</u>.**

Northern GI Endoscopy Center

PATIENT PRE-ADMISSION HISTORY

please complete and bring to appt

Patient Name:

Primary Physician: Ht: Wt:

Reason for Visit:

***GRAY AREAS FOR OFFICE USE ONLY**

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 YES NO	Special Instructions/ Changes
					☐ ☐	
					☐ ☐	
					☐ ☐	
					☐ ☐	
					☐ ☐	
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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

R4.1

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? ☐Yes ☐No
		Inhaler (with you ☐Yes ☐No)
		Skin Test \ ☐Positive ☐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 funtions, regardless of whether an Advance Directive to the contrary is in place

Patient initals: ☐

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 o**Yes** o**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.