

**Gastroenterology Associates of Northern New York, PC**  
**Board Certified Gastroenterology**

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Five Irongate Center  
Glens Falls, NY 12801  
**518-793-5034**

[www.giassociatespc.com](http://www.giassociatespc.com)

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**COLONOSCOPY WITH EXTENDED MIRALAX/GATORADE PREP**

**Name:** \_\_\_\_\_ **Appointment Date** \_\_\_\_\_

**PROCEDURE TIME:** \_\_\_\_\_ **ARRIVAL TIME:** \_\_\_\_\_

**Location: Northern GI Endoscopy Center, 5 Irongate Center, ENTRANCE C.**

**Patient parking is provided across from Entrance C. Please do not arrive prior to 6:45 AM.**

**GPS directions: 25 Pine Street, Glens Fall, NY 12801**

**\*\*\*\*\*NOTHING BY MOUTH FOR 2 HOURS PRIOR TO YOUR PROCEDURE TIME\*\*\*\*\***

**Planning for Your Colonoscopy with Extended Prep**

Please read all preparation instructions. You must complete a bowel preparation.

The restricted diet and bowel preparation help ensure a thorough examination of the colon.

- Arrange for a responsible adult (18 years or older) to drive you home. **You must have a responsible adult with you even if you take a taxi or use medical transport.**
- You will be receiving intravenous sedation for your procedure; this will limit what you can do after the procedure until the following day. **You may not drive or operate machinery for the next 24 hours and a responsible adult must stay with you for 24 hours following the procedure.**
- Please wear comfortable, loose fitting clothing and leave valuables at home.
- The gold colored Pre-Admission History form **must** be completed prior to your procedure. Please bring the completed form to your exam.
- Please bring your insurance card and photo ID on the day of the exam
- You will be at the endoscopy center 2 ½ - 3 hours from time of arrival to discharge.

**You are strongly encouraged to watch our colonoscopy preparation and procedure videos at [www.giassociatespc.com](http://www.giassociatespc.com) The 3 minute videos will help with your understanding of the colonoscopy procedure and the necessary preparation for your exam.**

It is very important that you keep this scheduled appointment. If you must cancel or reschedule your colonoscopy appointment, please **call 518-793-5034 at least 7 days in advance**. Patients failing to cancel their colonoscopy appointment within 7 days will be billed an administrative fee of \$100 by Gastroenterology Associates of Northern NY, P.C. This fee must be paid prior to rescheduling your procedure or scheduling future appointments with our practice. If you have any questions regarding the need to cancel due to illness or other health issues, contact our office or our physician on call (after hours or on weekends)

## **Purchase the following bowel prep supplies (over-the-counter):**

- **One** 10 oz. bottle of Magnesium Citrate (preferred) **OR** four Dulcolax (bisacodyl) tablets.
- **Three** 119 gram containers of Miralax (generic polyethylene glycol is acceptable).
- **Three** 32 oz. bottles of Gatorade (no red, blue, green or purple). G2 or Powerade may be substituted. G2 may be easier tolerated due to less sugar and carbohydrates. Many patients prefer to drink these beverages chilled.

## **Medications:**

- **If you are diabetic** and take oral diabetic agents, please do not take these medications on the day before and day of colonoscopy. If you take insulin, we will give you specific instructions for insulin on the day before and day of colonoscopy. If you have not received specific instructions for your diabetic medications, please call our office.
- **If you take anticoagulant medications (blood thinners) or anti-platelet medications such as:**

**WARFARIN (Coumadin, Jantoven)**

**PRADAXA (Dabigatran)**

**XARELTO (Rivaroxaban)**

**ELIQUIS (Apixaban)**

**SAVAYSA (Edoxaban)**

**PLAVIX (Clopidogrel)**

**BRILINTA (Ticagrelor)**

**EFFIENT (Prasugrel)**

**PLETAL (Cilostazol)**

We will give you instructions for holding these medications prior to the colonoscopy after consulting with the prescribing physician. If you have not received specific instructions from our office within 10 days of your scheduled procedure, please call our office.

- You may continue to take daily medications including aspirin and nonsteroidal anti-inflammatory medications (NSAIDs) such as Advil, Aleve, Celebrex, Bextra, and Voltaren. You may also take Tylenol (acetaminophen).

## **5 days before your colonoscopy**

- **Stop taking iron pills** and multivitamins containing iron.
- **Stop eating high fiber foods – do not eat popcorn, seeds, nuts, salad, whole grain breads, raw fruits or raw vegetables: well-cooked fruits and vegetables are acceptable.**
- Please notify our office if you have chronic constipation or have had inadequate bowel prep for a previous colonoscopy. You may require a special set of instructions.

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

Please follow the instructions below. Do not follow the instructions printed on the Miralax container.

**TWO DAYS BEFORE YOUR COLONOSCOPY DAY: \_\_\_\_\_**

- **No solid food from now until your procedure is done.** Begin a clear liquid diet (below) for breakfast, lunch and dinner. Drink at least 6-8 glasses of clear liquids during the day to avoid dehydration.
- **At 6:00 PM:** Mix one 119 gram container of Miralax with one 32 oz. container of Gatorade, G2 or Powerade. Shake until the Miralax is dissolved. **Begin drinking the Miralax/Gatorade solution at a rate of one 8 oz. cup every 15 minutes until the solution is gone.**
- Continue to drink clear liquids until bedtime.

**THE DAY BEFORE YOUR COLONOSCOPY DAY: \_\_\_\_\_**

- **Drink clear liquids for breakfast lunch and dinner.** Drink at least 6-8 glasses of clear liquids during the day to avoid dehydration.
- **At 5:00 PM: Drink one bottle of Magnesium Citrate.**
- **At 6:00 PM:** Mix one 119 gram container of Miralax with one 32 oz. container of Gatorade, G2 or Powerade. Shake until the Miralax is dissolved. **Begin drinking the Miralax/Gatorade solution at a rate of one 8 oz. cup every 15 minutes until the solution is gone.**
- Continue to drink clear liquids until bedtime.

**THE DAY OF YOUR COLONOSCOPY DAY: \_\_\_\_\_**

- **3 hours prior to leaving home for your colonoscopy appointment:** Mix one 119 gram container of Miralax with one 32 oz. Container of Gatorade. Shake until Miralax is dissolved. **Begin drinking the Miralax/Gatorade solution at a rate of one 8 oz. cup every 15 minutes until the solution is gone.**
- You must complete the entire preparation. **If your preparation is successful, you will pass yellowish to clear liquid when you have a bowel movement. If you have any questions regarding your preparation, please call our office at 518-793-5034.**
- You may drink clear liquids and take necessary oral medications up to 2 hours prior to procedure time.

\*\*\*\*\***NOTHING BY MOUTH (including water, gum and mints) AFTER**\_\_\_\_\_\*\*\*\*\*

**You may drink these clear liquids:**

- Gatorade, G2, Powerade, Pedialyte  
Crystal Light Lemonade
- Coffee or tea (black only)
- Chicken or beef broth
- Carbonated beverages – sodas and flavored seltzers
- Apple juice, white cranberry juice or white grape juice
- Jell-O, popsicles or italian ices (without fruit or cream)
- Pulp free orange juice

**Do not drink these liquids:**

- Milk or non-dairy creamer
- Juice with pulp

**NO RED, BLUE, GREEN OR PURPLE LIQUIDS**

### **Helpful Tips:**

- Plan to stay near a bathroom. The laxative solution will cause you to pass loose stool.
- Rarely, people may have nausea or vomiting with the prep. If this occurs, take a break for up to 30 minutes and rinse your mouth with water. Continue drinking the solution.
- Most patients will begin having bowel movements during the evening hours but occasionally bowel movements will not begin until nighttime or early morning. **In addition, you may find our 3 minute colon preparation video at [www.giassociatespc.com](http://www.giassociatespc.com) helpful in addressing any questions you may have. Please call our office at 518-793-5034 if you have any questions regarding your preparation for the exam.**
- Pre-moistened wipes, hemorrhoid cream or Vaseline may be used to reduce anal discomfort during preparation process. Do not use suppositories.

**Due to 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 12801. If our office does not receive payment within the above time frame, your procedure will need to be rescheduled.**

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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  
Humana  
Magnacare  
Martins Point  
Medicare  
MVP  
New York State Empire Plan  
New York State Medicaid  
Shared Health Network  
Today's Options  
United Healthcare

If your insurance plan is not listed above, please call our billing office at 518-793-5034 to discuss your insurance coverage and financial responsibility.

You will need to contact the facility where you are scheduled for your protection to discuss whether they participate with your insurance company. They will also be able to answer questions about pathology services. If you are scheduled for your procedure at Northern GI Endoscopy Center, 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 Center.

# Northern GI Endoscopy Center

## PATIENT PRE-ADMISSION HISTORY

please complete and bring to appt

Patient Name:

Primary Physician:	Ht:	Wt:	<b>*GRAY AREAS FOR OFFICE USE ONLY</b>
Reason for Visit:			

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

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**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"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	
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					<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	
					<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

TIME
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PHYSICIAN SIGNATURE

/

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: _____

**Continued on next page ►**

**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

continued on next page>



**STATEMENT OF COMPLIANCE**

Since you will be given a sedative for this examination, **YOU MUST HAVE** a responsible adult (18yrs or older) to take you home and accompany you into your residence. As well, you must have a responsible adult (18yrs or older) 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.

**Name of Responsible Adult (at least 18yrs old) driving you home:**

**Responsible Adult (at least 18yrs old) 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 phone # \_\_\_\_\_

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

As part of NGI 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 and assure no complications have arisen.

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**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_