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

Kelly Knill, RPA-C
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FLEXIBLE SIGMOIDOSCOPY WITH SEDATION

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

PLANNING FOR YOUR FLEXIBLE SIGMOIDOSCOPY WITH SEDATION

Please follow the "Fleet Enema Preparation" on the next page.

- 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.

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 prep supplies (over the counter):

- **Two Fleet Enemas (plain, not oil).** Fleet Enema (green and white box) is a brand of enema which is available at your local pharmacy.

Medications:

- **If you are diabetic** and take oral diabetic agents, please do not take these medications on the day of sigmoidoscopy. If you take insulin, we will give you specific instructions for insulin on the evening prior and day of sigmoidoscopy. 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 sigmoidoscopy 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).

PLEASE NOTE: If your insurance plan requires a referral form from you 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.

THE DAY BEFORE YOUR SIGMOIDOSCOPY DAY: _____

- **You may consume a normal diet the day before the exam. DO NOT EAT ANY SOLID FOOD AFTER MIDNIGHT.**

THE DAY OF YOUR SIGMOIDOSCOPY DAY: _____

- **You may drink clear liquids ONLY (SEE BELOW) up to 2 hours prior to your procedure.**
- **You may take your morning medications with water up to 2 hours prior to your procedure.**

NOTHING BY MOUTH (including water, gum and mints) AFTER_____

- **90 minutes prior to your procedure appointment, administer the Fleets enemas rectally, as directed on the package. The enemas should be given one after the other, not simultaneously and should be retained as long as possible.**
- **Please do not use any other laxative preparation for the examination.**
- **Please call our office at 518-793-5034 if you have any questions regarding your preparation for the exam.**

You may drink these clear liquids:	**DO NOT DRINK THESE 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	• **MILK, CREAM OR non-dairy creamer** • Juice with pulp **NO RED, BLUE, GREEN OR PURPLE LIQUIDS**

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:

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

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:_____

_____

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 funtions, regardless of whether an Advance Directive to the contrary is in place

Patient initals: _____

PATIENT SIGNATURE **RN Signature**

MD Signature

continued on next page>

STATEMENT OF COMPLIANCE

Since you will 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.

un

Patient Signature:_____ Date:_____

Revised 06/17