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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Rachel Baker, FNP-C

UPPER ENDOSCOPY

Name:_____**Appointment Date**_____

PROCEDURE TIME:_____ **ARRIVAL TIME:**_____

Location: Saratoga Surgery Center on Rte. 50 in Saratoga, approximately 0.6 miles north of Exit 15

If you have not been contacted by the Surgery Center Registration staff within 10 days of your scheduled appointment, please call 518-583-8344

Planning for Your Upper Endoscopy

Please read all preparation instructions.

- 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 Endoscopy 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 Surgery 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)

Medications:

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

UPPER ENDOSCOPY PREPARATION INSTRUCTIONS

THE DAY BEFORE YOUR UPPER ENDOSCOPY DAY:_____

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

THE DAY OF YOUR UPPER ENDOSCOPY 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_____

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.

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: _____