

Gastroenterology Associates of Northern New York, PC
Board Certified Gastroenterology

Kevin J. Herlihy, M.D.
Michael P. Chase, M.D.
William M. Bauer, M.D.
John M. Coombes, M.D.
Ovais Ahmed, M.D.

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

www.giassociatespc.com

Kelly Knill, RPA-C
Lynn Collette-Zachar, FNP-C
Brittany Smith, FNP-C
Courtney Stewart, ANP-C
Rachel Baker, FNP-C

FLEXIBLE SIGMOIDOSCOPY

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**

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

Planning for Your Flexible Sigmoidoscopy

Please follow the “Fleet Enema Preparation” on the next page.

- 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 endoscopy center approximately 1 hour 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 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)

DAY OF YOUR FLEXIBLE SIGMOIDOSCOPY DAY: _____

- You may consume a normal diet and take all of your usual medications on the day of the exam unless otherwise directed by our office.
- **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.

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.

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.

Gastroenterology Associates of Northern New York, PC
Board Certified Gastroenterology

Kevin J. Herlihy, M.D.
Michael P. Chase, M.D.
William M. Bauer, M.D.
John M. Coombes, M.D.
Ovais Ahmed, M.D.

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

www.giassociatespc.com

Kelly Knill, RPA-C
Lynn Collette-Zachar, FNP-C
Brittany Smith, FNP-C
Courtney Stewart, ANP-C
Rachel Baker, FNP-C

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.

*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?
<input type="checkbox"/> NONE				

Previous Surgeries / Hospitalizations:

Date	
	<input type="checkbox"/> NONE

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

<input type="checkbox"/>	Colon Cancer
<input type="checkbox"/>	Colon Polyps
<input type="checkbox"/>	Family History Colon Polyps
<input type="checkbox"/>	Family History Colon Cancer
<input type="checkbox"/>	Rectal Bleeding
<input type="checkbox"/>	Black Stools
<input type="checkbox"/>	Occult(Hidden) Blood Stool
<input type="checkbox"/>	Ulcerative Colitis
<input type="checkbox"/>	Crohn's Disease
<input type="checkbox"/>	Excessive Gas
<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Irritable Bowel Syndrome
<input type="checkbox"/>	Diverticulosis / itis
<input type="checkbox"/>	Ostomy
<input type="checkbox"/>	Reflux/Heartburn
<input type="checkbox"/>	Difficulty Swallowing
<input type="checkbox"/>	Barrett's Esophagus
<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	Nausea
<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	Abdominal Pain
<input type="checkbox"/>	Hiatal Hernia
<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	Yellow Jaundice
<input type="checkbox"/>	Gallbladder Disease
<input type="checkbox"/>	Other: _____

Respiratory

Current/History of: ☐ No Problems

<input type="checkbox"/>	Cough
<input type="checkbox"/>	Smoker
<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	Sleep Apnea
<input type="checkbox"/>	Inhaler (with you: <input type="checkbox"/> Yes <input type="checkbox"/> No)
<input type="checkbox"/>	Skin Test Date: _____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative
<input type="checkbox"/>	Other: _____

Circulatory

Current/History of: ☐ No Problems

<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	Palpitations
<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Mitral Valve Prolapse
<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	Heart Valve Replacement
<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	Stroke (TIA, CVA)
<input type="checkbox"/>	Irregular Heart Beat
<input type="checkbox"/>	History Rheumatic Fever
<input type="checkbox"/>	Prolonged Bleeding from Cut
<input type="checkbox"/>	Coronary Artery Bypass Surgery
<input type="checkbox"/>	Coronary Artery Stent Placement
<input type="checkbox"/>	Angioplasty
<input type="checkbox"/>	Other: _____

Metabolic/Endocrine

Current/History of: ☐ No Problems

<input type="checkbox"/>	Diabetes (<input type="checkbox"/> Diet controlled <input type="checkbox"/> Insulin)
<input type="checkbox"/>	Low Blood Sugar
<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	Other: _____

Neurological

Current/History of: ☐ No Problems

<input type="checkbox"/>	Seizures/Epilepsy
<input type="checkbox"/>	Migraines
<input type="checkbox"/>	Psychological or Mental Illness
<input type="checkbox"/>	Chronic Pain
<input type="checkbox"/>	Other: _____

Miscellaneous

Current/History of: ☐ No Problems

<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Kidney Disease/Renal Failure
<input type="checkbox"/>	Joint Replacement (i.e. hip, knee)
<input type="checkbox"/>	Radiation Therapy
<input type="checkbox"/>	Bleeding Problems/Anemia
<input type="checkbox"/>	Previous Blood Transfusions
<input type="checkbox"/>	Hernia
<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	Possibly Pregnant (last period date: _____)
<input type="checkbox"/>	Dislocated Jaw
<input type="checkbox"/>	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: _____

The Saratoga Hospital

Endoscopy
Pre-Admission History

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 contacted 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: _____