FLEXIBLE SIGMOIDOSCOPY

Patient's Name_____Appointment Date_____

Location_____

You are scheduled for a flexible sigmoidoscopy. Flexible sigmoidoscopy is a routine procedure, generally done without sedation. The usual preparation is two Fleets enemas (plain, not oil), given approximately 90 minutes prior to your appointment time. These enemas can be purchased over the counter at any pharmacy and should be administered as directed on the package. These are given one after the other, not simultaneously, and should be retained for as long as possible. You may eat normally and take all of your usual medications the day of the exam, unless otherwise directed by our office. Other preparation, including the use of laxatives, is not generally recommended.

During the exam, you will be lying on your left side with your knees slightly flexed. A rectal exam is performed by the physician. The sigmoidoscope, which is flexible and has a light at the tip, is introduced into the rectum. The exam may cause a slight degree of crampy abdominal pain. This discomfort is usually mild and transient. The procedure takes approximately 5 to 10 minutes. The procedure is considered very safe and complications, such as bowel perforation, are exceedingly rare (less than 1:20,000 procedures).

The forwarded gold colored Northern GI Endoscopy Center Pre-Admission History form must 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).

Patients failing to cancel their flexible sigmoidoscopy appointment at least 48 hours in advance will be billed an administrative fee of $100 by Gastroenterology Associates of Northern, N.Y., PC. 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).

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.

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***

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

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:_____

_____

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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***

Living Will **Health Care Proxy**

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.

Patient Signature:_____ **Date:**_____

Revised 06/15