

COLONOSCOPY

NAME: _____

You are scheduled for **COLONOSCOPY** at the GI Center at the Glens Falls Hospital on _____ (date). Your procedure is scheduled for _____ but it will be necessary for you to arrive at _____ to allow for our staff to prepare you for the procedure. **Please do not arrive at the GI Center prior to 7:00 AM as the GI Center does not open until 7:00 AM and the doors are locked until that time. The GI Center closes in the late afternoon and patients must be picked up no later than 4:30 PM.**

Patients failing to cancel their colonoscopy appointment at least 7 days 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 with our practice. 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).

The Glens Falls Hospital scheduling staff will be calling to pre-register you prior to your procedure. If you have not been contacted by the Glens Falls Hospital scheduling staff within 10 days of your scheduled appointment, please call 926-5333.

On the day of the exam, please report directly to the GI Center, located past the emergency room entrance on the left (east) side of the hospital around to the back of the hospital. The parking lot for the GI Center is located on the back (south) side of the hospital immediately adjacent to the entrance to the GI Center. Whenever possible, please leave valuables including personal belongings at home. As well, please remove all jewelry, including piercings, and leave at home.

COLONOSCOPY is an examination of the large intestine by means of a flexible tube with a bright light. This flexible tube is called a colonoscope and it relays images from inside your colon to a video screen viewed by the physician. After you have completed your preparation at home, you will come to the hospital, where the test will be explained, and you will be given an opportunity to ask questions prior to signing an informed consent form. After you change into your gown and robe, the nurse will insert a small intravenous catheter into a vein in your arm and tape it in place to administer medication before and during the test, as needed. You will be lying on the cushioned table on your left side.

When you are comfortable, the doctor will examine your rectum, and then insert the lubricated tip of the tube. During this test, some people experience gas-like sensations or cramps. This relates to the insufflation of air necessary for a proper examination. You might also experience the feeling that you need to move your bowels. This is caused by the presence of the tube and the air. If needed, more medication will be given to keep you comfortable. The examination usually takes approximately twenty minutes. The instrument is able to suction any leftover laxative solution and the air put into you, as needed for your comfort. It is possible to take biopsies and remove polyps through a channel in the tube and this procedure is painless.

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The instrument is able to suction any leftover laxative solution and the air put into you, as needed for your comfort. It is possible to take biopsies and remove polyps through a channel in the tube and this procedure is painless. When the procedure has been completed, you will be taken to a recovery room where you will rest for a period of time. Then, the intravenous catheter will be removed from your arm and you may use the bathroom and get dressed. The doctor will then explain the results to you and your family. **Patients can expect to be at the GI Center for 2-1/2 to 3 hours from the time of admission for the procedure to the time of discharge, but you must be picked up no later than 4:30 p.m.**

PLEASE NOTE:

- 1. Please follow instructions “MiraLax/Gatorade Preparation for Colonoscopy” on the next “attached” page. This includes instructions regarding dietary restrictions 3 days prior and oral intake on the day prior and day of procedure.**
- 2. Our office will provide you with specific instructions if you are taking any of the following medications:**
 - Insulin**
 - Anticoagulant medications (blood thinners) such as warfarin (Coumadin, Jantoven), Pradaxa (dabigatran), Xarelto (rivaroxaban), Eliquis (apixaban), Savaysa (edoxaban)**
 - Antiplatelet medications such as Plavix (clopidogrel), Brilinta (ticagrelor), Effient (prasugrel)**
- 3. If you are a diabetic and taking oral diabetic agents, please do not take these medications the day before and the day of your procedure.**
- 4. If you are taking steroid medications (e.g. prednisone, Decadron, Medrol), please discuss this with our office prior to your procedure.**
- 5. Do not take iron supplements or a multivitamin that contains iron for seven (7) days prior to your colonoscopy.**
- 6. All other medications may be continued, including aspirin and nonsteroidal anti-inflammatory drugs (NSAIDs e.g. Celebrex, Bextra, Voltaren, Naprosyn, Motrin, Advil, Aleve). If you have any questions regarding your medications, please contact our office.**
- 7. Since you may be given intravenous sedation for this examination, you must have a responsible adult drive 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 our office to allow for rescheduling of your procedure. Sedation for your procedure cannot be administered unless these arrangements are completed.**
- 8. If your insurance plan requires a referral from your primary care physician, please confirm that our office has received a referral to cover this procedure. If your insurance plan requires pre-authorization for this procedure, please confirm that our office has obtained the pre-authorization.**
- 9. The forwarded green colored Glens Falls Hospital GI Center Interdisciplinary Pre-admission History & Physical 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)**
- 10. Due to the 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. If our office does not receive payment within the above timeframe, your procedure will need to be rescheduled.**

MIRALAX/GATORADE PREPARATION FOR COLONOSCOPY

You are scheduled for COLONOSCOPY at the GI Center at the Glens Falls Hospital. You will need to purchase the following laxatives **over the counter** at your local pharmacy:

1. **One** 10 oz. bottle of Magnesium Citrate (if only cherry flavored is available, this is allowed despite the red color). If preferred, **four** tablespoons of Milk of Magnesia or **four** Dulcolax (bisacodyl tablets) may be substituted for the Magnesium Citrate.
2. **Two** 119 gram containers of MiraLax (powder).

You will also need to purchase **two** 32 oz. bottles of Gatorade (avoid red, blue, green or purple colored Gatorade). If preferred, G2 or Powerade may be substituted. **To ensure that your bowel is cleansed adequately, please follow the instructions below for the MiraLax/Gatorade colonoscopy prep. DO NOT follow the instructions printed on the MiraLax container.**

Three (3) days prior to examination – Do not eat high fiber foods such as popcorn, beans, seeds (flax, sunflower, quinoa), multigrain bread, nuts, salad/vegetables, or fresh and dried fruit.

The Day Before Examination

1. Drink only clear, sweetened liquids for breakfast, lunch, and dinner. No solid food, no milk or milk products allowed.
2. At 5:00 p.m. drink **one** bottle of Magnesium Citrate or take **four** tablespoons of Milk of Magnesia or **four** Dulcolax tablets.
3. At 6:00 p.m. mix **one** 119 gram bottle of MiraLax in 32 oz. of Gatorade, G2 or Powerade. Shake the solution until the MiraLax is dissolved.
4. Drink 1 (one) 8 oz. glass of the MiraLax/Gatorade solution every 15 minutes until the solution is gone. (Four 8 oz. glasses in approximately 1 hour).
5. Continue drinking clear fluids until bedtime.

The Day of Examination

1. Three (3) hours prior to leaving for your appointment, mix **one** 119 gram bottle of MiraLax in 32 oz. of Gatorade, G2 or Powerade.
2. Drink 1 (one) 8 oz. glass of the MiraLax/Gatorade solution every 15 minutes until the solution is gone. (Four 8 oz. glasses in 1 hour).
3. Clear liquids and oral medications may be ingested until 2 hours prior to your scheduled procedure time. No solid food, no milk or milk products allowed.
4. Appear for examination as scheduled.

Note: Plan to have a bathroom or commode very accessible.

If you have any questions as you proceed with the laxative preparation for your colonoscopy, please call our office to speak with the physician on call.

CLEAR LIQUID DIET

Only These Liquids Are Allowed:

| | |
|----------------|--|
| Soups: | Bouillon, broth (including chicken, turkey, & beef), consommé. |
| Beverages: | Tea, coffee, decaffeinated coffee, Kool-Aid, carbonated beverages, including sodas (dark colored colas & root beer are allowed), flavored seltzers, Gatorade, Crystal Light. |
| Juices: | Apple, white grape, grapefruit, lemonade, limeade, and orange juice (juices should have no pulp). |
| Desserts: | Jell-O, water ices, sorbet, iced popsicles. |
| Miscellaneous: | Sugar, salt, hard candy. |

Note: Please avoid red, blue, green or purple colored liquids. Please do not add milk or cream to any beverages, including coffee or tea.

Note: Premoistened bathroom wipes may be used to reduce any anal discomfort during preparation.

Recipe for High caloric Lemonade (240 calories per 8 ounce cup):

Lemon juice – 2 ounces or ¼ cup

Corn Syrup – 10 to 12 ounces or approximately 1 to 1-1/2 cups

Water to make 1 quart

**GLENS FALLS HOSPITAL GI CENTER
INTERDISCIPLINARY PRE-ADMISSION
HISTORY & PHYSICAL**

**PLEASE COMPLETE THESE FORMS & BRING
THEM WITH YOU TO YOUR EXAM**

GI Physician: _____

Date: _____

Why are you having this exam? _____

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? _____

PLEASE CHECK ANY PROBLEMS THAT YOU CURRENTLY HAVE OR HAVE A PERSONAL HISTORY OF:

Gastrointestinal: No Problems

Current / History Of

- Nausea/Vomiting
- Reflux / Heartburn
- Hiatal Hernia
- Difficulty or changes in swallowing
- Ulcer
- Abdominal pain
- Liver disease
- Yellow jaundice
- Hepatitis
- Colon polyps
- Colon cancer
- Rectal bleeding
- Black stools
- Occult (hidden) blood stool
- Excessive gas
- Gallbladder disease
- Irritable bowel syndrome
- Ulcerative Colitis or Crohn's disease
- Family history colon cancer
- Family history colon polyps
- Diverticulosis / itis
- Constipation
- Diarrhea
- Ostomy
- Hemorrhoids
- Hernia: Location _____

Other: _____

Respiratory: No Problems

Current / History Of

- Cough
- Asthma
- Tuberculosis
- Wheezing
- Shortness of Breath
- Pneumonia
- Emphysema/COPD
- Sleep Apnea CPAP device? Yes No

Other: _____

Metabolic / Endocrine: No Problems

Current / History Of

- Diabetes
- Thyroid Disease
- Low Blood Sugar

Other: _____

Circulatory: No Problems

Current / History Of

- Chest Pain
- Palpitations
- High blood pressure
- Mitral valve prolapse
- Pacemaker/Defibrillator
- Heart valve replacement
- Heart attack
- Stroke (TIA/CVA)
- Irregular heart beat
- Blood Clots (DVT's, Pulmonary emboli)

Other: _____

Neurological: No Problems

Current / History Of

- Seizures / epilepsy
- Migraines
- Chronic Pain

Miscellaneous: No Problems

Current / History Of

- Pain Control Device
- Arthritis
- Kidney disease / Renal failure / Dialysis
- TMJ
- Joint replacement (hip, knee)
- Radiation therapy
- Prolonged bleeding from cut
- Previous blood transfusions

History of cancer: _____

Could you be pregnant? YES NO

Last menstrual period _____

Last prostate exam _____

Appetite: increase/decrease/unchanged

Unintended weight change +/- 10 lbs. YES NO

Medication List
Allergies

(list): _____

Have you ever had complications to anesthesia or sedation? _____

Alert: Please include all vitamins, herbs, over the counter medicines, & prescriptions. Attach additional sheet if necessary.

| Medication/Strength | Dose | Frequency | Last Dose | Why do you use this medication? |
|---------------------|------|-----------|-----------|---------------------------------|
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Do you routinely take:

Aspirin yes no Last Dose: _____
 Non-Steroidals (eg. Ibuprofen) yes no Last Dose: _____
 Anticoagulants (blood thinners, Coumadin, Jantoven, Plavix, Pradaxa, Xarelto, Eliquis, Effient, Ticlid, Lovenox, Brilinta) yes no Last Dose: _____
 Antibiotics (within last 3 weeks) yes no Last Dose: _____
 Were you instructed by your doctor to discontinue any of the above medications? yes no
 Do you have a surgically placed IV line? yes no
 Height: _____ Weight: _____

PLEASE LIST ALL PREVIOUS SURGERIES _____

PLEASE PLACE
 ANTI-COAGULANT DISCHARGE
 INSTRUCTIONS HERE

 OFFICE USE ONLY

FUNCTIONAL ASSESSMENT

LEARNING NEEDS

Preferred modes of communication: verbal sign language written other _____

Preferred Language: English Spanish French Other _____

Is the patient able to read? Yes No

Is the patient able to write? Yes No

SENSORY DEFICITS

Do you have: Dentures Yes No Loose Teeth Yes No Body Piercings Yes No

Glasses or Contacts Yes No Hearing Impairment Yes No Hearing Aids Left Right

Have you had any recent/significant change in caring for yourself, dressing, bathing, or toileting? Yes No

Do you have any difficulty shopping, cooking or feeding yourself? Yes No

ADVANCED CARE DIRECTIVES

Living Will on File Yes No Health Care Proxy on File Yes No Information Given Yes No

PSYCHOSOCIAL:

Are there any spiritual, cultural, special practices or needs that we should be aware of during your stay? Yes No

If yes, describe: _____

Do you:

Drink coffee? No Yes How much? _____

Drink alcohol? No Yes How much? _____

Do you smoke? No Yes How much? _____

DOMESTIC VIOLENCE:

Because violence can be common in our lives, we'd like to provide community resource information to you. If you do not feel safe at home and/or have any questions, please speak directly with your health care professional.

*Warren/Washington County: 518-793-9496

*Saratoga County: 518-583-0280 (Daytime), 518-584-8188 (After Hours)

*NY State Domestic Violence Hotline: 1-800-942-6906, Spanish line: 1-800-942-6908

Would you like to discuss any domestic violence, abuse or neglect concerns with your healthcare provider? Yes No

Authorization for Follow Up Communication

I am aware that I will be contacted after my procedure by the GI Center to follow up on my recovery.

Within 3 days after the procedure I would like to be called at this # _____

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

Patient Signature: _____ Date: _____

STATEMENT OF COMPLIANCE

Since you will 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 your physician's 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.

Please state name of the person driving you home: _____

Responsible adult staying with you for the next 24 hours: _____

Patient Signature: _____ Date: _____

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.