UPPER G.I. ENDOSCOPY WITH BARRX

NAME:_____

You are scheduled for an **UPPER GI ENDOSCOPY WITH BARRX** 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 upper GI endoscopy with BARRX 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. 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.

UPPER GI ENDOSCOPY is an examination of your esophagus, stomach and first part of your small intestine, using a flexible tube called an endoscope which has a bright light on it. When you arrive at the GI Center, 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 then lie on the cushioned table on your left side. When you are comfortable, the doctor will put the tip of the small tube in your mouth, toward the back of your tongue, and ask you to swallow. You will be able to breathe normally, and the nurse will suction any extra saliva or mucus from your mouth during the test, if necessary. You may feel some fullness or perhaps the need to belch. This relates to the insufflation of air necessary for a proper examination. This is normal and most patients are comfortable enough to fall asleep during the examination. The examination usually lasts approximately ten to fifteen minutes.

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. **Do not eat or drink anything or take oral medications after midnight the night before your examination, if scheduled for 10 A.M. or earlier. If scheduled after this time, clear liquids and oral medications may be ingested until 3 hours prior to your scheduled procedure time.**
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 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. **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.**
6. **Since you will 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.**
7. 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.
8. **The forwarded green colored Glens Falls Hospital GI Center Interdisciplinary Pre-Admission History & Physical form <u>must</u> 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).**
9. **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 <u>within the above timeframe,</u> your procedure will need to be rescheduled.**

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.

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?

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:**_____