

GASTROENTEROLOGY, LTD.

ENDOSCOPY PREP INSTRUCTIONS

You have been scheduled for EGD procedure.

Do not eat any solid food after midnight the night before your procedure. However, you may have clear liquids until 4 hours before the procedure, then nothing to eat or drink until after your test is complete.

Allowed Clear Liquids

Water	Gatorade
Apple Juice	Soft Drinks
White Grape Juice	Tea
Chicken or Beef Bouillon	Coffee (no milk, may use sweeteners)
Jell-O	Popsicles

Note: No Milk or Milk Products, No Red or Purple Colored Liquids

*If you have any questions or problems, please call us at 481-4817, option 4.
After hours, call 481-4817 and ask to speak with the on-call doctor.*

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Location of Procedure:

_____ Location A: Colon Cancer Prevention and Endoscopy Center of Virginia Beach, 1101 First Colonial Road, **Please go to Suite 400, 4th floor.**

_____ Location B: Sentara Virginia Beach General Hospital, 1060 First Colonial Road, **Please enter through the door under the green awning on Facilities Lane, behind the hospital.**

Patient Name: _____

Date of Procedure: _____

Check-in time: _____

Procedure time: _____

Please arrange for transportation home. Our policy requires a responsible adult escort you from the Endoscopy suite, drive you home, and stay with you for the remainder of the procedure day. You may not meet your ride in the parking lot. Public transportation or taxicabs are **NOT ALLOWED**, unless you are accompanied by a responsible adult.

Our office will obtain a pre-authorization from your insurance company for your procedure; however, you are responsible to verify your insurance benefits. Please bring your insurance information and co pay on the day of your procedure. Please do not bring any other valuables.

Regular medications should be taken as usual until the morning of your procedure. Only blood pressure and heart medications should be taken on the day of your exam. You may also take Tylenol.

Stop taking Coumadin, Plavix or any blood thinners 5 days prior to your procedure. Your last dose will be on _____. **If you take aspirin, do not stop it.** Regular medications should be taken as usual until the morning of your procedure. Only blood pressure and heart medications should be taken on the day of your exam. You may also take Tylenol.

We ask that your driver stay in our waiting room during your procedure.

If cancellation is necessary, please notify our office at least seventy-two (72) hours before by calling 481-4817, option 1. Please be aware that we have reserved a physician, three nurses and equipment for your procedure. Without adequate notice, there will be a \$75 cancellation fee. Thank you for your cooperation.

If you have any questions concerning your procedure or your instructions please call us at 481-4817, option 4.

Colon Cancer Prevention and Endoscopy Center of Va. Beach

Patient ID

PRE-ENDOSCOPY ASSESSMENT

Date: _____

Arrival Time: _____

Chart Drop Time: _____

YOU WILL BE HERE TODAY FOR APPROXIMATELY 90 MINUTES, SO YOUR DRIVER SHOULD STAY WITH YOU.

Who will be driving you home today? _____ Is he/she here now? Yes No

Phone number in case we need to reach your driver: _____

Why are you having this procedure? Describe your symptoms _____

If there are any biopsies or laboratory tests, who do you authorize results be given to?

Name: _____ Relationship: _____

Do you have any valuables with you? Yes No

Are you wearing dentures/partials? Yes No

Are you wearing a hearing aid? Yes No

Do you have artificial joints or implants? Yes No

Are you wearing glasses/contact lenses? Yes No

Any previous problems with sedation? Yes No

Do you require antibiotics before you go to the dentist? Yes No

Do you take blood thinners? Yes No

(Heparin, Coumadin, aspirin, Ticlid, Persantine) Yes No

Date stopped: _____

Did you complete your bowel prep? Yes No

Last time you had solid food: _____

Liquids: _____

Are you pregnant? Yes No NA

Last menstrual period: _____ NA

All patients should rest today and resume normal daily activities tomorrow.

If you received sedation for your procedure:

- 1. Do not drive, operate machinery or perform heavy lifting until tomorrow.
2. Avoid making critical decisions or signing legal documents until tomorrow.
3. Do not drink any alcoholic beverages until tomorrow.
4. You may feel dizzy, lightheaded or sleepy on and off for 24 hours after your procedure. Do not stay home alone.

Completed by (Patient's signature) _____ Date _____ Time _____

Reviewed by (Clinical staff signature) _____ Date _____ Time _____

Reviewed by (Procedure nurse) _____ Date _____ Time _____

GASTROENTEROLOGY, LTD.

COLON CANCER PREVENTION AND ENDOSCOPY CENTER OF VIRGINIA BEACH

Consent for Upper Endoscopy (EGD)

PATIENT: _____ **PROCEDURE DATE:** _____

Authorization and Nature of this Procedure: I hereby request and authorize Dr. _____ and his designated associates/assistants to perform an **upper endoscopy (esophagogastroduodenoscopy/EGD), possible biopsy and possible esophageal dilatation** (widening the esophagus with special plastic tubes or balloon dilators). It has been explained to me that this procedure is an examination of the lining of my esophagus, stomach and a portion of the small intestine by use of a flexible scope, which is passed through the mouth and into the upper digestive tract. During this procedure, biopsies (tissue samples) may be removed. Occasionally when bleeding occurs, cautery may be necessary to stop the bleeding. If my physician identifies a narrowing in my esophagus, it may be dilated by passing soft, sequentially larger diameter instruments through it to stretch the narrowed section.

Risks and Complications: Every medical procedure has some degree of risk and the possibility of complications. My physician has explained to me and I understand that complications from this procedure include but are not limited to: bleeding, aspiration of stomach contents into the lungs, perforation or puncture of the wall of the upper GI tract, irregular heart beat, and very rarely, death. I am satisfied with the explanation of these possible risks and do not wish to have any further explanation given to me, although I have been advised that I am entitled to do so if I desire. I understand that I may be transferred to another facility in the event that a complication occurs. This decision will be made by my physician or designated health care provider.

Alternative Procedures or Treatment: My doctor has explained to me that alternative procedures are available which also include risks and complications. I am satisfied with my physician's explanation of these options and wish to proceed with an EGD. Such options may include x-rays, barium swallow, CAT scan, or no treatment.

Attendance of other Health Care Providers: I understand that physicians, nurses and assistants may be present to perform and assist with my EGD. I consent to the presence of these health care professionals and **I do** ___/ **I do not** ___ consent to *students/residents/personnel in training* to be present during my procedure.

Photographs: I understand that photographs and/or videotaping may be taken during my procedure for documentation of findings. **I do** ___/ **I do not** ___ consent to the use of these photographs to be used for teaching purposes. This may include the reproduction of the photographs for publication or to be used in part of a medical education program.

Tissue Disposal: I consent to the appropriate disposal of any body tissues removed during this procedure after the same tissue has been examined by a pathologist.

Anesthesia/Sedation: I consent to the administration of intravenous (IV) medications that will have a sedative effect on me. Possible complications from this may include but are not limited to pain during the administration of medications, soreness/swelling in the arm, cardiac or respiratory arrest, rarely an allergic reaction, which could cause death. I understand that I cannot drive after the procedure (until the following morning), should not sign any legal or important papers or perform tasks that require coordination. I should have a responsible adult with me for the remainder of the procedure day.

No Guarantee or Assurance: I acknowledge that no guarantee or assurance to the outcome of this procedure has been given to me. I do recognize that this is the best test for finding lesions in the upper gastrointestinal tract; however, I understand that this procedure has a low rate of missed lesions/diseases/diagnoses. Recognizing that there may be a failure to diagnose a problem, further testing might be recommended in the future. I know that I must report any persistent or unusual symptoms to my physician to help with detection of lesions or conditions, which might possibly have been missed despite the best clinical performance, by my physician.

No ADVANCE DIRECTIVES: I acknowledge that this facility does NOT recognize advance directives. During my care at this facility, all practical measures will be utilized to prevent loss of life. _____ (patient initial or signature)

Opportunity for Further Information: I understand that I am free to seek advice from other physicians if I choose. I know that I am also encouraged to ask questions regarding any aspect of this procedure.

Opportunity to Read this Document: I acknowledge by signing this consent that I have read this form in its entirety and fully understand it. I have had my questions answered to my satisfaction and agree and consent to this treatment.

DO NOT SIGN IF YOU HAVE FURTHER QUESTIONS

Signature of Patient or Authorized Person

Date

Authorized person's relationship to the patient: _____

Signature of Witness

Date

The above procedure(s) have been explained to the patient or authorized person to give consent for the patient. _____, M.D.

SAMPLE