UtahGastroenterology

St. George Office
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Gastroenterology - Liver Diseases - Diagnostic and Therapeutic Endoscopy

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PATIENT INFORMATION SHEET
COLONOSCOPY

You have been scheduled for an examination of the lower gastrointestinal tract (rectum, colon, or large bowel). This is done by looking at the lining of the large bowel by a lighted tube put into your rectum. In order to examine the colon completely, you will have to follow a special, colon preparation before the test. This will "clean" the bowel out. It is important **not to eat solid food once the preparation has begun,** until after the test. **Stop clear liquids three hours prior** to the procedure.

The morning of the test you will have your blood pressure and pulse checked. Then you will be asked to lie down on the examination table. A small IV catheter will be put into a vein in your arm or hand so that medicine to relax you can be given. The medicine that is usually given is Propofol. Once you are relaxed, the doctor will examine your colon with the colonoscope. The examination usually takes 20 minutes to 1 hour. If abnormalities are seen, biopsies (small pinches of tissue) can be taken through the tube. These biopsies are not painful. The biopsies are then sent to the laboratory for examination by microscope. The endoscope is taken out after the exam is completed. Most patients are awake enough to leave within an hour. However for safety reasons **you cannot drive** or operate dangerous machinery, tools or appliances, until the following day, as the full effect of the medicine wears off slowly. Before you leave, a check-out sheet will be given to you explaining the results of the test.

Possible complications from the test include abdominal pain or cramping, mild bleeding from the rectum and soreness, or redness and/or bruising at the IV site. In addition, more serious complication can occur. These include, but are not limited to, heart or breathing problems which occur in 0.2% of exams, perforation (making a hole in) or tears of the colon occurring in 0.12% of exams, bleeding which occurs in 0.09% of exams, and death, which are rare, occurring in less than 0.006% of exams. If a polyp is removed, the risk of perforation in 0.3% of exams, and bleeding in 1.7% of exams. If any of these complications occur, hospitalization, transfusions, or surgery may be necessary.
IF YOUR COLONOSCOPY HAS BEEN SCHEDULED FOR SCREENING (MEANING YOU HAVE NO SYMPTOMS WITH YOUR BOWELS)*, AND YOUR DOCTOR FINDS A POLYP OR TISSUE THAT HAS TO BE REMOVED DURING THE PROCEDURE, THIS COLONOSCOPY IS NO LONGER CONSIDERED A SCREENING PROCEDURE, IT IS CONSIDERED A SURGICAL PROCEDURE AND YOUR INSURANCE BENEFITS MAY CHANGE. PLEASE CHECK WITH YOUR INSURANCE COMPANY PRIOR TO STARTING THE BOWEL PREPARATION.
Any questions you have about this examination or its possible complications should be discussed with the doctor before the exam begins.

If you are on a prescribed blood thinner medication and are unclear about when to stop your medication, please contact our office for further clarification at 435-673-1149.

Please bring someone with you **to drive you home**, as you will be sedated for the exam. ***By law, you cannot drive the rest of the day of the colonoscopy***. The doctor will talk to you after the exam and will give you recommendations for diet, medication, follow up care, etc. Wear comfortable clothes, bring your glasses, hearing aids, insurance card(s) and completed forms. We will expect payment of co-pays, coinsurance and/or deductible at the time of service. If you have any questions please call (435) 673-1149 or visit our website www.utahgastro.com

PATIENT NAME:	PREFERRED NAME:	PHONE #	AGE	HT.	WT.
REASON FOR ADMISSION/ NAME OF PROCEDURE	PROCEDURE DATE	DOCTOR	PRIMARY CARE PHYSICIAN		

PLEASE LIST ALL PREVIOUS HOSPITALIZATIONS AND OPERATIONS (Indicate approximate year)

CHECK IF YOU HAVE HAD A BAD REACTION TO ANESTHESIA? ☐ YES ☐ NO

HAS A BLOOD RELATIVE HAD A BAD REACTION TO ANESTHESIA? ☐ YES ☐ NO

HEALTH HISTORY

YES	NO	HAVE YOU EVER HAD:
		DIABETES CONTROLLED BY DIET PILLS INSULIN BLOOD SUGAR RESULTS
		HYPOGLYCEMIA (Low blood sugar)
		THYROID PROBLEMS
		HEART PROBLEMS (Rheumatic Fever, Murmur, Chest Pain, Heart Attack, Irregular Heartbeat, EKG changes, Angina, Valve Replacement, Pacemaker, Heart Failure, etc.)
		BLOOD CLOTS, TRANSFUSION PROBLEMS, OR BLEEDING TENDENCY (Hemophilia, Anemia, Sickle Cell, etc.)
		HIGH BLOOD PRESSURE
		STROKE (Weakness/Numbness on one side, Difficulty Speaking, Loss of Vision, etc.)
		SEIZURES (Epilepsy, Convulsions, Blackouts, etc.)
		NEUROLOGICAL PROBLEMS (Loss of Sensation, Numbness, Tingling, etc.)
		SEVERE HEADACHES
		LUNG PROBLEMS (Asthma, Chronic Cough, Pneumonia, Wheezing, Shortness of Breath, Emphysema, Abnormal Chest X-ray, Oxygen, etc.)
		TUBERCULOSIS/TB
		SLEEP APNEA (Breathing Interruption During Sleep, CPAP, etc.)
		LIVER PROBLEMS (Jaundice, Hepatitis, etc.)
		KIDNEY, BLADDER, OR PROSTATE PROBLEMS (Infections, etc.)
		STOMACH PROBLEMS (Ulcer, hiatal hernia, reflux, heartburn, nausea/vomiting, etc.)
		BOWEL PROBLEMS (Irritable Bowel, Diverticulosis, Diarrhea, etc.)
		BACK TROUBLE (Disc Problems, Numbness/Tingling of Hands or Feet, etc.)
		BROKEN BONES OF HEAD, NECK, OR SPINE OR RESTRICTIONS IN MOVEMENT OR DIFFICULTY OPENING MOUTH (TMJ, etc.)
		ARTHRITIS
		MUSCLE DISORDERS (MD, Myasthenia Gravis, Myositis, MD, etc.)
		CANCER
		MENTAL HEALTH/PHOBIAS (Anxiety, Depression, Psychosis, etc.)
		MENTAL DISABILITY (Confusion, Memory Loss, Downs Syndrome, etc.)
		SKIN PROBLEMS (Eczema, Fragile, Rashes, Skin Breakdown, etc.)
		OTHER MEDICAL PROBLEMS/COMMENTS
		ANY ILLNESS, COLD, COUGH OR FEVER WITHIN THE LAST WEEK?
		RECENT EXPOSURE TO ANY COMMUNICABLE DISEASES? (Chicken Pox, Measles, etc.)
		IF AGE 18 OR OLDER
		Do you have advance directives/living will?_____ Did you bring a copy with you?_____
		Would you like more information about advanced directives/living will? Information provided by_____

YES	NO	
		DO YOU HAVE A HISTORY OF SMOKING? PACKS PER DAY DATE QUIT
		DO YOU DRINK ALCOHOLIC BEVERAGES? HOW OFTEN HOW MUCH
		DO YOU HAVE A HISTORY OF SUBSTANCE ABUSE OR ADDICTION?
		DO YO HAVE ANY OF THE FOLLOWING: ☐ False Teeth ☐ Braces ☐ Jewelry Removed ☐ Loose Teeth ☐ Retainers ☐ Body Piercing ☐ Bridges ☐ Chipped Teeth ☐ Hearing Aids ☐ Capped Teeth ☐ Contact Lenses
		ARE YOU RECEIVING TREATMENT FOR GLAUCOMA?
		DO YOU HAVE ANY SPECIAL NEEDS OR CONCERNS? ☐ Hearing_____ ☐ Speech_____ ☐ Vision_____ ☐ Translator_____ ☐ Language_____ ☐ Learning Needs_____ ☐ Limitations_____
		DO YOU HAVE ANY PHYSICAL LIMITATIONS?
		DO YOU HAVE ANY ENVIRONMENTAL CONCERNS? (Room Temperature, Lighting, etc.) ☐ _____
		DO YOU HAVE ANY SPECIAL REQUESTS?
		DO YOU CURRENTLY NEED ASSISTANCE TO GET AROUND THE HOUSE, DO ERRANDS, AND TAKE CARE OF YOUR PERSONAL NEEDS?
		WOULD YOU LIKE TO DISCUSS ANY CONCERNS OR FEARS REGARDING THIS PROCEDURE?
		WOMEN: IS THERE A POSSIBILITY YOU ARE PREGNANT? LAST MENSTRUAL PERIOD: ARE YOU BREASTFEEDING?
		DATE OF LAST IBUPROFEN, ASPIRIN OR BLOOD THINNERS. DATE: _____ LIST: _____
		PATIENT'S OR SIGNIFICANT OTHERS SIGNATURE RELATIONSHIP DATE **X**
		COMMENTS:
		History Completed ☐ Reviewed by: ☐ RN _____ ☐ CRNA _____ ☐ MD _____

St. George Endoscopy
Patient Medication Reconciliation Form

Patient Sticker

Name:	Date of Birth:	Age:
Allergies: ☐ Yes ☐ No known allergies	**Latex Allergy** ☐ No ☐ Yes ☐ Testing performed for Latex allergy	

Allergy (Drug)	Reaction	Allergy (drug)	Reaction

Current Prescriptive Medications.

Name of Medication (print please)	Dose	Route (Oral/Topical/Etc.)	Frequency	Last Dose Taken

Herbals, Vitamins, Supplements, Non-Prescriptive Drugs.

Name of Supplement (print please)	Dose	Route (Oral/Topical/Etc.)	Frequency	Last Dose Taken

New Medications or New Dosages you should take after discharge.

Name of Medication (print please)	Dose	Route (Oral/Topical/Etc.)	Frequency

Signature of Patient/Responsible Person: _____ Date: _____

Nurse Signature: _____ Anesthesia Provider: _____ Physician Signature: _____

St. George Endoscopy Center, LLC

Last Name:	First	Mi	Marital M S W D	Sex	Age	Date of Birth
Home Address:			City		State	Zip
Alternative Address:						
Spouse or Parent			Patient Cell: Spouse/Partner Phone:			
Primary Care Physician			Referring Physician			
Primary Insurance Company			Policy Holder's Name:			
Secondary Insurance Company			Policy Holder's Name:			
Email:						

Signature of Patient or Responsible:

_____ Date: _____

St. George Endoscopy Center
368 East Riverside Drive, Suite B
St. George, UT 84790-6898

Anesthesia Services Offered at St. George Endoscopy Center

St. George Endoscopy Center utilizes anesthesia services provided by a Certified Registered Nurse Anesthetist (CRNA), who is highly trained and specialized to safely administer your sedation. The CRNA will carefully deliver medications while monitoring your vital signs during your procedure. Based upon your medical history and condition, your physician will work in consultation with the CRNA to determine the best type of sedation to administer, customized just for you. Please note that the charge for anesthesia services are separate from and in addition to routine charges for endoscopic services rendered by your physician, the surgery center, and pathology charges (biopsies, if taken). These charges are generally covered by your health insurance policy. In the event that your insurance will not cover anesthesia services for your endoscopic procedure, alternative self payment arrangements for this important services can be made with AmSurg St. George Anesthesia, LLC

_____ **(Initial Here)** I agree to receive anesthesia services as recommended by my physician, and I acknowledge that my insurance will be billed and I will be responsible for payment of any deductibles and co-insurance.

Non Coverage of anesthesia for services provided

_____ **(Initial Here) I am aware that my insurance company may not cover this service and I acknowledge that I will be billed the following fees if my insurance company denies payment. $200 self-pay rate flat fee for anesthesia services will be billed to the patient.**

_____ _____

Patient Signature Date

_____

Print Name