Colonoscopy involves insertion of a flexible viewing tube through the anus and rectum into the large intestine. This allows the physician to examine the lower gastrointestinal tract for any abnormalities. It is a very safe test with an extremely low probability of complications. Rarely do adverse reactions to medications used during the procedure, bleeding after biopsies or polyp removal, or a perforation through the bowel wall occur. Some abdominal cramping, during and after procedure, is common.

During a colonoscopy, it is very important for the lower gastrointestinal tract be clean for a good examination, so please follow these instructions.

- **Start a clear liquid diet** one day before your scheduled procedure. If you can hold it up to light and see light shining through, then it is a clear liquid. **Examples:** Water, Beef or Chicken Broth, Popsicle, Jell-O, Coke, Dr. Pepper, Sprite, Coffee with nondairy creamer, Tea, White Cranberry Juice, White Grape Juice, Gatorade. **NO Solid Food. NO Red, Purple, or Orange. No Milk or Milk products. NO Alcoholic Beverages.**

- **MoviPrep: Day before your colonoscopy** Mix 1 packet A and 1 packet B with water. **6:00 P.M.** Begin drinking MoviPrep. Drink 8 oz. of solution every 15 minutes for 1 Hour. Then, **Drink 16 oz.** of clear fluids. Prepare morning prep by mixing 2nd packet A and 2nd packet B. **Morning of exam:** 4-5 hours before procedure, repeat MoviPrep. Drink 8 oz. of this solution every 15 minutes for 1 Hour. Then, **Drink 16 oz.** of clear fluids.

- **Golytely: Evening before 6:00 P.M.** Begin drinking Golytely. Drink one 8 ounce glass every 15 minutes. Drink one gallon of solution in a 3-4 hour period. Drink ½ of Gallon and discard remaining (3:00P.M. take 4 Dulcolax tablets)

  Prep may be refrigerated 24 hours prior to drinking.

Upper Endoscopy involves insertion of a flexible viewing tube through the mouth into the esophagus, stomach, and duodenum. This allows the physician to examine the upper gastrointestinal tract for abnormalities. It is a very safe test with an extremely low probability of complications. Rarely do adverse reactions to medications used for the procedure, bleeding after biopsies or a perforation through the bowel wall occur. You may have a sore throat for a short time after the procedure.

The following applies for both Colonoscopy and Upper Endoscopy:

- Nothing to drink after midnight. Unless otherwise directed (i.e. MoviPrep).
- Morning medications may be taken with small amount of water.
- Discontinue your Iron and Aspirin tablets **3** days before your procedure.
- If you are a Diabetic or on Blood Thinners, please ask for special instructions.
- You will be required to have someone **drive** you home, because the medications will make you drowsy.
1. Please bring someone with you to drive you home. The medication that will be given to you during your procedure makes it impossible for you to drive for 24 hours. This person will also be able to be present when the doctor talks to you to help you remember what he tells you.

2. After you enter the main door you will see two doors. GO through the door on the left that says "Amarillo Endoscopy Center." There will be a clip board on the desk. Please sign in before you set down.

3. When the nurse calls you back to get ready, your family will be asked to stay in the waiting room. Your family will be called to come in and sit with you after the procedure. No family will be allowed to watch the procedure.

4. The procedure itself will take approximately 20 minutes. After the procedure you will stay in the recovery room for approximately 30 minutes before being discharged. You will be given a drink before you are dismissed unless you are being sent for further tests.

5. Following your colonoscopy you may experience some abdominal discomfort and bloating. This will be relieved by walking around and lying on your left side.

6. Following an EGD you may experience a sore or scratchy throat which may be relieved by using chloraseptic spray or throat lozenges.

7. Discharge instructions will be given to you and your family before leaving and you will have a copy of the instructions to go home with you.
To assure a speedy admission process, please make sure every question is answered accurately and completely.

Primary Care Doctor __________________________

What is the reason for your procedure? ________

____________________________________________________

Have you had or are you being treated for: Circle Yes or No

Yes No - Heart trouble type __________________________
Yes No - Pacemaker
Yes No - CD (bring your card) Internal Cardiac Defibrillator
Yes No - High blood pressure
Yes No - Lung disease type ____________________________
Yes No - Stroke (Paralysis)
Yes No - Cancer type ____________________________
Yes No - Epilepsy or seizures
Yes No - Cerebral Palsy/Previous Head Injury/Birth Defect
Yes No - Diabetes type ____________________________
Yes No - Thyroid disease
Yes No - Jaundice or hepatitis type_______________________
Yes No - Bleeding tendency
Yes No - Kidney disease
Yes No - Liver disease type_______________________
Yes No - Muscular Dystrophy/Multiple Sclerosis
Yes No - Muscle weakness
Yes No - Arthritis
Yes No - Back trouble
Yes No - Neck trouble
Yes No - Nervous system disease type_______________________
Yes No - Fainting or Dizziness
Yes No - Glaucoma
Yes No - Stomach problems (Hiatal Hernia/heartburn/indigestion)
Yes No - Sleep apnea (Bring CPAP machine/mask)
Yes No - TMJ problems Temporal Mandibular Joint: Jaw
Yes No - Bridges Yes No - Dentures
Yes No - Dental Caps Yes No - Loose Teeth
Yes No - Contact lens
Yes No - Hearing Aid
Yes No - Do you currently have a head/chest cold?
Yes No - Do you have an infusion port? If Yes, what Physician maintains it? ___________________ What are your Doctors orders for use and repacking? ___________________

______________________________________________________________

ALLERGIES: (food, medicines, etc) Types of reaction:
______________________________________________________________
______________________________________________________________
______________________________________________________________

______________________________________________________________

FOR WOMEN ONLY
Yes No - Are you pregnant?
Last Period ____________

Have you taken or used any of the following in the last 2 weeks?

Circle Yes or No

Yes No - Alcoholic beverages
Yes No - Steroids
Yes No - Diet drugs
Yes No - Recreational drugs (i.e., marijuana, etc.)
Yes No - Blood thinners Date stopped _______________________
Yes No - Tobacco pks/day

Medications: (include vitamins and herbal)

Must fill out medications with dose and how often even if this information was filled out in the clinic.

Name __________________________ mg ________ How Often? ________

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

Weight ________ Lbs. Height __________

Anesthesia History

Date of last anesthesia

Yes No - Abnormal reactions? Type____________
Yes No - Nausea, vomiting?
Yes No - Relatives with abnormal reactions to anesthetics?

Past Surgical Procedures and Hospitalizations:

(including Psychiatric Treatment)

______________________________________________________________
______________________________________________________________
______________________________________________________________

Name of person taking you home __________________________

Relationship __________________________

Phone number of person taking you home __________________________

Patient/ Guardian Signature __________________________
TO THE PATIENT: Your physician wants you to be informed about your condition and the recommended diagnostic procedure(s) to be performed so that you may make the decision whether or not to undergo the procedure after knowing the risks involved. This consent is meant to simply make you better informed so that you give or withhold your consent.

It is recommended by the physician performing your procedure(s) that the use of a conscious sedation be administered. Your physician or RN (assisting with your procedure) under the supervision of your physician, will be administering to you an intravenous conscious sedation agent. This agent allows the patient to tolerate the procedure(s) while minimizing anxiety and discomfort.

INTRAVENTOUS CONSCIOUS SEDATION is a controlled state of depressed consciousness that allows protective reflexes to be maintained and permits appropriate response by the patient to physical and verbal commands. Intravenous Conscious Sedation involves risks and hazards in addition to those associated with the proposed procedure(s). Any one of the following may result from the use of an Intravenous Conscious Sedation Agent: Cardiac/Respiratory arrest, respiratory difficulties, drug reaction, convulsions, brain damage or death.

1. I (we) understand that Intravenous Conscious Sedation involves additional risks and hazards but I (we) request the use of an Intravenous Conscious Sedation Agent for the relief and protection from pain during the planned procedure(s). I (we) realize the anesthesia agent may have to be changed possibly without advance explanation to me (us).
2. I (we) fully understand that serious illness, injury or death can result from the use of an Intravenous Conscious Sedation Agent as described above.
3. I (we) have discussed my condition with my physician and have been given full opportunity to ask questions about my condition, and the option of receiving an Intravenous Conscious Sedation Agent, alternative forms involved, and I (we) believe that I (we) have sufficient information to give this informed consent.
4. I (we) do hereby authorize the administration of an Intravenous Conscious Sedation Agent to the patient by the physician or by a qualified substitute.
5. I (we) certify that this form has been fully explained to me, that I (we) have read it or had it read to me, and I (we) understand its contents.

______________________________________________________  _____________________________
Patient Signature/Legally Authorized Representative    Date/Time

______________________________________________________
Witness                                                Physician Signature
Informed Consent

☐ Colonoscopy, Possible Biopsy, Possible Polypectomy
☐ Esophagogastroduodenoscopy, Possible Biopsy, Possible Dilatation

Explanations of Procedure
This procedure provides direct visualization of the digestive tract with a lighted instrument. Your physician has advised you to have this type of examination. The following information is presented to help you understand the reasons for and the possible risks of this procedure.

Principle Risks and Complications of Gastrointestinal Endoscopy
Gastrointestinal Endoscopy generally has a low risk procedure, however, all of the below complications are possible. Your physician will discuss their frequency with you if you desire, with particular reference to your own indications for gastrointestinal endoscopy. You must ask your physician if you have any unanswered questions about your test.

1. The bowel may be punctured. This can cause leakage of bowel contents into the abdomen. The risk is greater when polyps are removed, depending on how large the polyp is. Fluids and antibiotics will be given and further surgery may be needed. This may require a longer stay in the hospital.
2. Bleeding from the bowel following a biopsy or damage of large blood vessels may occur. The risk may be greater the larger the polyp. Management of this complication may consist only of careful observation, or may require transfusions or possibly a surgical operation.
3. The procedure may not be able to be completed due to bowel disease or other problems.
4. Polyps or cancer may be missed. The risks are higher if you bowel is not cleaned properly. It is important that you follow the instructions to clear you bowel before the procedure.
5. Although gastrointestinal endoscopy is an extremely safe and effective means of examining the gastrointestinal tract, it is not 100 percent accurate diagnosis. In a small percentage, a failure of diagnosis or a misdiagnosis may result.

Alternative to Gastrointestinal Endoscopy
Other diagnostic studies or therapeutic procedures, such as medical treatment, x-ray and surgery are available. Another option is to choose no diagnostic studies and/or treatment. Our physician will be happy to discuss these options with you.

I consent to the taking and publication of any photographs made during my procedure for the use in the advancement of medical education. I certify that I understand the information regarding gastrointestinal endoscopy. I have been fully informed of the risks and possible complications of my procedure. I hereby authorize and permit.

__________ A. Trehan, M.D.
__________ S. Pathapati, M.D.
__________ K. Banwait, M.D.

And whomever he may designate as his assistant to perform upon me the following:
At the time of our examination, the lining of the digestive tract will be inspected thoroughly and possibly photographed. If an abnormality is seen or suspected, a small portion of tissue (biopsy) may be removed or the lining may be brushed. These samples are sent for laboratory study to determine if abnormal cells are present. If small growths (polyps) are seen, they may be removed.

If any unforeseen condition arises during this procedure calling for (in the physician's judgment) additional procedures, treatments or operations, I authorize him to do whatever he deems advisable. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the result of the procedure.

I am aware that in the event of a life-threatening emergency the Center will perform any necessary emergency procedures and transfer me to an acute care facility.

_______________________________
Patient Signature/Legally Authorized Representative

_______________________________
Witness

_______________________________
Date/Time

_______________________________
Physician Signature
Disclosure of Ownership

The Amarillo Endoscopy Center is a corporation one of your physicians may have financial interest in. The physician has become an owner as a result of their commitment to quality health care and service to their patients. Please be advised of the following:

1. For patients other than Medicare and Medicaid, a surgical deposit of $300 is required prior to Endoscopy procedures. Cash, credit card or check will be accepted.
2. A schedule of typical fees for services provided by the facility is available upon request.
3. You have right to choose where to receive services.
4. Alternative source of services are available at: Baptist Saint Anthony's Hospital or Northwest Texas Hospital.

By my signature below, I am acknowledging my, understanding of this notice of Disclosure of Ownership interest on the date set forth below.

_____________________________  ____________________________
Patient Signature                  Date

_____________________________  ____________________________
Patient’s Guardian/Representative  Relationship

_____________________________
Witness

Medicare/Medicaid

I certify that the information given by me in applying for payment under *TITLE XVIII OF THE SOCIAL SECURITY ACT is correct.

I authorize any holder of Medical or other information about me, to release to the SOCIAL SECURITY ADMINISTRATION or its intermediaries or carriers any information needed for this or a related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for medical services to the physician or organization furnishing the service or authorize such physician or organization to submit a claim to Medicare for payment to me.

I request that payment under the medical insurance program be made to AMARILLO ENDOSCOPY CENTER on any bills for services furnished by AMARILLO ENDOSCOPY CENTER during the next 12 month period.

All Other Insurances

I hereby authorize AMARILLO ENDOSCOPY CENTER to submit a claim to my insurance carrier or its intermediaries to issue payment check(s) directly to the organization/physician rendering the covered services for the next 12 month period.

I authorize AMARILLO ENDOSCOPY CENTER to furnish any information needed for this or any related claim to my insurance carrier or its intermediaries regarding services rendered.

_____________________________  ____________________________
Patient Signature                  Date
Advanced Directive Information

Directive to Physician, Family or Designated Other (Living Will)
Directives are written or oral instructions that tell your doctor(s), other health care providers and family what your wishes are should you develop a terminal condition. Upon execution of the Directive, a copy must be presented and made part of each admission to the hospital. Please note that any invasive procedure will suspend and existing directive.

Do you have a directive? (Living Will)  Did you bring it?
Yes  No  Yes  No

Medical Power of Attorney
This form appoints someone in writing to make medical decisions for you if you become unable to do so. Upon execution of the Medical Power of Attorney, a copy must be presented and made part of each admission to the hospital.

Do you have a Medical Power of Attorney?  Did you bring it?
Yes  No  Yes  No

If you answered no to any of the above you may do one of the following:

☐ Provide an existing document   ☐ Execute a new document   ☐ Choose not to execute

If a copy is not available, what are the patient’s wishes?

______________________________________________________________________________

Legal Next of Kin

Name ___________________________  Relationship (Circle one)
Address __________________________
________________________________________
Phone #’s __________________________
Name-Medical Power of Attorney __________________________
________________________________________
Patient Signature __________________________  Power of Attorney
Date _______________