

What do I need to know about my colonoscopy?

Is there a preparation?

Yes! Although preparations differ, *all* require you to be on a liquid diet for at least one full day prior to your examination. You will also need to pick up the medication listed on your preparation about one week prior to your procedure. If you do not prep, the colonoscopy cannot be done.

What about my medications?

1. Stop taking aspirin (except for baby aspirin), anti-arthritis medication, Ibuprofen or blood thinning drugs seven days before the day of your colonoscopy. Check with the prescribing doctor prior to stopping these drugs. **Notify us if you take Coumadin, Plavix or Aspirin by calling 317-841-8090 extension 229.** You may take Tylenol.
2. Do not take iron, herbal supplements or vitamin E seven days prior to the exam. You may continue taking multi-vitamins including those containing iron until the day of your procedure.
3. If you take more than 500 mg of vitamin C per day, you must continue to take the vitamin C every day, including the day of your colonoscopy.
4. Do not take any insulin or anti-diabetic medication on the morning of your colonoscopy. Notify the doctor that you have not taken any anti-diabetic drugs.
5. You may take heart, seizure or steroidal medications as usual. Continue Prednisone type medications as usual. Hold all other medications on the day of procedure.
6. If you normally take antibiotics for dentist appointments, please notify the doctor before your colonoscopy. You may need to be given antibiotics before your procedure.

What is a colonoscopy?

Colonoscopy is a state-of-the-art procedure that uses a video colonoscope to examine and visualize the entire large intestine or colon. The colonoscope is a long, flexible, fiber-optic tube that is about the thickness of a finger. The tube has a miniature television camera in its tip.

During the procedure, the colonoscope's video camera allows the doctor to examine the entire lower gastrointestinal tract via a television screen. Any suspicious or abnormal areas that are found are photographed, and tissue samples are taken for further study and examination. The doctor will also remove any polyps. The procedure usually takes less than 30 minutes, but if polyps must be removed, it can last longer.

Why a colonoscopy?

Colonoscopy can find the cause of such symptoms, as rectal bleeding or changes in bowel habits, that x-rays cannot. A barium enema xray examination shows only shadows and doesn't clearly show cancers and small lesions. Colonoscopy is also an important procedure for detecting colon cancer. Almost all colon cancers start as polyps (benign growths of the colon) that later become cancerous. Thanks to the colonoscope, most polyps and tumors can be removed early, safely and without surgery.



Preparing for a colonoscopy

To ensure that any and all abnormalities can be seen clearly during the procedure, the colon must be completely empty of waste material. Solid matter retained in the colon prolongs the colonoscopy and can reduce its effectiveness and decreases the diagnostic accuracy, making a repeat examination necessary. To avoid this, you will need to follow the pre-colonoscopy diet carefully and follow the preparation instructions. Diet is a very important part of the cleansing process. See medication precaution section as they relate to your medications. **If you are pregnant, please notify the nurses immediately.**

During the colonoscopy

You will be given a sedative medication intravenously that relaxes and makes you sleepy. While lying on your side, the colonoscope is inserted into the rectum and gently advanced along the colon. The colonoscope is then slowly withdrawn while the colon is again carefully examined. If there is discomfort, it is very mild. You will likely fall asleep during the examination and may not, because of the medication, even remember having the test done.

Recuperation

After the colonoscopy, expect to be kept in the recovery room a short time, until most of the effects of the medication have worn off. Because you may not remember all the details explained during or after the procedure, the doctor will relay the results of the colonoscopy to the person who accompanies you. If this is not agreeable, notify the doctor and nurses before the procedure begins.

Note: Due to the medication, you will not be able to drive home after a colonoscopy. An adult must accompany you to the medical facility and remain until discharged.

Please do not plan return to work on the day the colonoscopy is performed. Consider resting at home at least two hours because the medication may make you feel drowsy for the rest of the day. Resume taking your usual medications on their regular schedule unless otherwise instructed by the doctor. Your normal diet and activities also can be resumed unless otherwise instructed. If the doctor finds a polyp and removes it, you may be placed on a liquid diet for 12 hours and restricted from any heavy lifting for 24 hours. If a biopsy was taken during the colonoscopy, you should call the office for the results in one week.

Possible complications

Colonoscopies are safe and very low in risk. Most colonoscopies are free from complications and the benefits of colonoscopy greatly outweigh the risk. However, like any other effective diagnostic or therapeutic procedure, complications can occur. Possible complications are perforation of the colon and heavy bleeding. A perforation of the colon is a puncture to the bowel wall, but is quite rare. Persistent bleeding may require hospitalization and even surgery. If you develop abdominal pain that is not gas related or excessive rectal bleeding (more than a spoonful and recurrent) , the doctor should be contacted immediately.

Colonoscopy with MagSenna Prep IV

PURCHASE YOUR PREP PRODUCTS EARLY

- Citrate of Magnesia 10 ounce bottle- Available over-the-counter
 - 30 Senokot tablets- Available over-the-counter
- 1- Bisacodyl suppository-Available over-the-counter

THE DAY BEFORE YOUR PROCEDURE

6:00am	Begin a full liquid diet. This includes fruit juices without pulp, broth, coffee, tea, sodas, plain jello, popsicles. Please note: Avoid red colored liquids because red dye could be mistaken for blood in your colon.
1:00 pm	Take 10 (ten) Senokot tablets with 8 oz of water. Drink 8 oz of water or clear liquid each hour to avoid dehydration.
4:00pm	Take 10(ten) Senokot tablets with 8 oz of water.
5:00 pm	Drink 5 ounces of Citrate of Magnesia followed by 8oz of water.
6:00 pm	Drink 5 ounces of Citrate of Magnesia followed by 8oz of water.
8:00pm	Take 10 (ten) Senokot tablets with 8 oz of water.

***Make sure you have adequate liquid intake during your preparation to avoid dehydration and this may include Ensure, Sustacal or Boost products.**

***You may have hard candy such as lemon drops during your preparation.**

****Nothing to eat or drink for 8 hours prior to your scheduled procedure.**

Helpful Hints:

- Remain at home after beginning your preparation.
- If you are diabetic, please consult your treating physician and coordinate medication/insulin adjustments during your preparation and day of procedure.
- If you have cardiac or other chronic illnesses, please coordinate care with your treating physician.

THE DAY OF YOUR PROCEDURE

***** At least 2 hours before your scheduled arrival time, Give yourself (1) Bisacodyl suppository.**

1. **Do not eat or drink anything 8 HOURS prior to your Colonoscopy**, or it may be canceled. It is not safe to have a colonoscopy and sedation when your stomach contains food.
2. **Have a driver take you to your Colonoscopy.** Note: Driver must remain at the Center during the entire procedure and drive you home.
3. **Please leave all valuables at home.**

Have someone accompany you to the Facility and arrive at _____

- Surgery Center Plus Inc. 7430 N. Shadeland Ave #100, Indpls (317) 841-8005
- Community Hospital North, Outpatient Department, 7150 Clearvista Dr. Indpls
- Community Hospital East, Outpatient Department, 1500 N. Ritter Ave. Indpls
- Riverview Hospital, Outpatient Department 395 Westfield Road, Noblesville
- Other: _____

For more information please visit our website at, www.colonrectalcare.com

Please note: If you cancel or reschedule your procedure, a 48 hour notice is required or you will be subject to a \$100.00 fee (\$25.00 physician fee and \$75.00 facility fee.) rev 10/1/09



Social Security Number:

Last Name:

First Name: M.I.

Nick Name: Sex: F M Age: Date of Birth:

Address: _____

Zip: _____ City: _____ State: _____

Driver License Number: _____

Email Address: _____

Note: Primary, Secondary and Cell phone numbers are used by this office to contact and/or to leave messages.

Primary Phone: - - Ext:

Is this number: Home Work Cell other: _____

Secondary Phone: - - Ext:

Is this number: Home Work Cell other _____

Other Phone: - - Ext:

Is this number: Home Work Cell other _____

If minor, list guardian (parent): _____

Address: _____

Zip: _____ City: _____ State: _____

Home Phone: _____

Name of primary physician involved in your care:

Last Name: _____ First: _____

Address: _____

City: _____ State: _____ Phone: _____

Marital Status: Single Married Divorced Widowed Other

Alternative contact name (Not Spouse) _____

Address: _____

Zip: _____ City: _____ State: _____

Phone: _____

To whom may we release information?

Spouse Patient Your Voice Mail Other

Patient's employer: _____

Address: _____

Zip: _____ City: _____

State: _____ Phone: _____

Spouse employer: _____

Address: _____

MD Requesting Consultation: _____ (First name) _____ (Last name)

Address: _____

- Rama Jager, MD, PhD
- Shekar Narayanan, MD
- Arun Gowdamarajan, MD
- Ateet Shah, MD

Primary Insurance Subscriber:

Self Spouse Parent Other

Note: If other than patient, please complete every line, or we may be unable to file claims with your insurance for you

Insurance Co. Name: _____

Address: _____

Zip: _____ City: _____ State: _____

Phone: () _____

Subscriber Name (If other than self): _____

Sex: F M Date of Birth: _____

Subscriber's Social Security Number: _____

Relationship to Patient: Self Spouse Parent

Subscribers Employer: _____

Address: _____

Zip: _____ City: _____ State: _____

Phone: () _____

Policy #: _____

Group #: _____

Plan #: _____

Secondary Insurance Co. Name: _____

Address: _____

Zip: _____ City: _____ State: _____

Phone: () _____

Subscriber Name (if other than self): _____

Sex F M Date of Birth: _____

Subscribers Social Security Number: _____

Relationship to Patient: Self Spouse Parent

Subscriber's employer: _____

Address: _____

Zip: _____ City: _____ State: _____

Phone: () _____

Policy#: _____

Group# _____

Plan #: _____

Do you have a third insurance company? Yes/No

Company Name: _____

How did you hear about us? Doctor Friend/Relative

Yellow Pages Insurance Provider Book Billboard Other

Insurance: As a courtesy to me, my care will be billed to my insurance carrier and remain my responsibility. I agree to forward all insurance payments to this office. I authorize release of medical information necessary to process claim and authorize payment of medical benefits to my physician.

Billing: Interest will be charged on all outstanding patient balance after 30 days. If after reasonable notice of any balance due on my account, payment is not made, I will be responsible for collection attorney and court costs.

Interest: I understand that my physician may have an ownership or investment interest in Surgery Center Plus, an outpatient surgery center. I acknowledge that any questions I may have regarding such interest will be explained and discussed with me in substance in order to concur knowledgeably, within reason, in accepting his referral for treatment. Further, I understand that I may choose to be referred to another health care entity without consequence.

Privacy and Security: I acknowledge that I have received the Center Plus Privacy Notice and Red Flags Rule.

Signature: _____ **Date:** _____

HEALTH HISTORY DATA SHEET

Current Health

Height: _____ Weight: _____ Per CRC scale
 B/P: _____ Pulse: _____

What prompted this visit? _____

Primary MD: _____ Cardiologist: _____

MD requesting consultation: _____

New health problems or surgeries since your last visit: _____

Yes No History of Present Illness

- Blood with Bowel movement
- Enough blood to turn toilet water red
- Rectal irritation and itching
- Hemorrhoidal bleeding
- Hemorrhoidal swelling
- Rectal Pain
- Constipation
- Black tarry stools
- Loose or Frequent Stools
- Abdominal pain, bloating, cramping
- Stomach pain after eating
- Nausea, vomiting
- Difficulty swallowing
- Heartburn/indigestion
- Other symptoms: _____
- Allergy to egg or soy
- Allergy to Latex

Name/dose/frequency taken None

Drug allergies		<input type="checkbox"/>
Narcotics used last 10 years		<input type="checkbox"/>
Current Medications	_____ _____ _____	<input type="checkbox"/>
Over the counter medications		<input type="checkbox"/>

Current Medical Problems None

Constitution:	<input type="checkbox"/> Lack of appetite <input type="checkbox"/> Chills/Fever <input type="checkbox"/> Weight loss	<input type="checkbox"/>
Eyes:	<input type="checkbox"/> Vision changes	<input type="checkbox"/>
Lungs:	<input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Chronic cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Active TB	<input type="checkbox"/>
Heart :	<input type="checkbox"/> Chest pain on exertion	<input type="checkbox"/>
Stomach:	<input type="checkbox"/> Spitting up blood	<input type="checkbox"/>
Blood:	<input type="checkbox"/> Bleeding tendency <input type="checkbox"/> Anemia	<input type="checkbox"/>
Urinary:	<input type="checkbox"/> Blood in urine <input type="checkbox"/> Hesitancy <input type="checkbox"/> Painful urination <input type="checkbox"/> Incontinence	<input type="checkbox"/>
Muscle/skeletal:	<input type="checkbox"/> Arthritis <input type="checkbox"/> Back pain	<input type="checkbox"/>
Skin:	<input type="checkbox"/> Skin rash/hives	<input type="checkbox"/>

This information is true and correct to the best of my belief

Patient/Guardian Signature _____ **Date:** _____

Printed Name: _____ **Date of Birth:** _____

Annual Health Review

Yes No

- Stroke, Date: _____
- Seizures: Date diagnosed: _____
- Emphysema: Oxygen dependent? Yes No
- COPD Oxygen dependent? Yes No
- Sleep Apnea
- Asthma
- Angina Use Nitroglycerin? Yes No
- Heart Murmur: Need antibiotics@ dentist? Yes No
- Heart attack, Date _____
- Pace Maker: Date placed: _____
- Irregular heart beat
- High blood pressure
- Replaced heart valve: Date: _____
- Rheumatic Heart Fever/Previous endocarditis Date: _____
- Arterial Grafts or stents: Date placed: _____
- Mitral Valve Prolapse/ Congenital heart defect
- History of inflammatory bowel disease(Crohn's, colitis etc)
- Cancer location: _____
- HIV positive
- Anemia
- Diabetes, (diet controlled or medication)
- Kidney disease: _____
- Prostate problems: _____
- Liver disease: _____
- Implants or Artificial Joints: Where: _____
- Skin disease: _____
- Other medical problems: _____

Surgery History

Yes No

- Hemorrhoidectomy When: _____
- Appendectomy
- Stomach operation
- Gallbladder operation
- Spleen removed
- Colon operation When: _____
- Hysterectomy
- Heart Surgery: Type: _____
- Colon polyp/ When _____
- Colonoscopy: when /by whom: _____

List other surgeries: _____

Social and Family History

Yes No

- Do you drink alcohol? Social Moderate Heavy
- Do you smoke? Packs per day _____ #years _____
- Have you ever used recreational drugs? Type: _____
- Do you have any disabilities? List: _____
- Family with cancer? Who: _____ Type: _____
- Family with polyps? Who: _____
- Mother Alive: Cause of death: _____
- Father: Alive: Cause of death: _____

Occupation: _____

Center use only

Updated: _____

ENDOSCOPY CONSENT

- SURGEON:**
- Rama Jager, MD, PhD
 - Shekar Narayanan, M.D
 - Arun Gowdamarajan, M.D
 - Ateet Shah, MD

I, the undersigned, give my permission to the doctors of *Colon & Rectal Care, Inc* and to an assistant surgeon as deemed appropriate by the doctor, dependent upon the procedure, to perform the procedure(s) listed below.

Please read, initial each section and sign below.

_____(Initial) **TITLE:**

- Colonoscopy, Biopsy, Polypectomy and possible Enteroscopy:** Examination of the entire large intestine with use of a video colonoscope (long flexible fiber optic tube). Tissue samples are taken of any abnormal areas and polyps will be removed.
- Flexible Sigmoidoscopy, Biopsy, Polypectomy:** Examination of rectum and sigmoid colon with a lighted fiber optic tube
- Pouchoscopy:** Examination of pouch mucosa and surveillance of anal transition zone with flexible fiber optic tube.
- Upper Gastrointestinal Endoscopy, Esophageal Dilatation:** Examination of upper digestive tract with video endoscope. Dilatation of esophagus can be done if stricture or narrowing is found.

_____(Initial) **SPECIFIC RISKS:** *Potential risks and complications related to above procedures include but are not limited to:*

- Perforation of the lining of the digestive tract by the instrument, which could result in leaking of digestive products into body cavities and would require surgery and even the possibility of fecal diversion with temporary or permanent ostomy. (Statistically this occurs less than once in every 2,000 procedures.)
- Bleeding may occur from a biopsy site or where a polyp was removed that may require additional surgery.
- Injury to organs adjacent to the colon such as spleen or liver. (Statistically, this occurs less than once in 10,000 procedures.)

_____(Initial) **GENERAL RISKS:** *Other potential risks include but are not limited to:*

- Allergic reactions to medications
- Irritation of the vein where medications were injected
- Aspiration of saliva and/or stomach contents
- Infection or fever that may require antibiotics
- Complications from pre-existing heart or lung disease or diabetes
- Injury or death from either known or unknown causes

_____(Initial) **GENERAL UNDERSTANDING:**

- Colonoscopy will not detect 100% of polyps or cancer. There is always a risk of a neoplasm that is not identified. If new or persistent symptoms of rectal bleeding, abdominal pain or alteration of bowel habits, I must contact the office for further diagnostic evaluation.
- The above stated procedure is recommended to me with the intention that it may contribute to my welfare, yet there is no assurance or guarantee that the procedure will achieve that objective. There is no assurance or guarantee that the same condition for which the procedure was recommended will not recur or that other problems secondary to the procedure do not develop postoperatively.
- It is imperative that the preparation instructions be followed exactly (and even then, the colon may not be completely clear of stool, thus decreasing the quality of the exam).

_____(Initial) **CONCLUSION:**

- I am aware of the nature of the above procedure and possible benefits.
- I am aware of the potential risks and complications related to the above procedure.
- I understand that if I am on any blood thinning medications I must obtain clearance from the ordering physician.

_____(Initial) In the event my procedure has been scheduled at Surgery Center Plus, I understand that my physician has an ownership or investment interest in the health care entity to which I am referred. I acknowledge that any questions I may have regarding such interest will be explained and discussed with me in substance in order to concur knowledgeably, within reason, in accepting his referral for treatment. Further, I understand that I may choose to be referred to another health care entity without consequence.

_____(Initial) I am aware that I must bring a responsible adult driver to remain at the Center during the procedure and drive me home.

_____(Initial) I am aware that I may not eat, drink or smoke 8 hours prior to my arrival time for the procedure or it may be cancelled.

_____(Initial) I am aware that I may be charged \$100.00 if I fail to provide a 48 hour notice of cancellation of my procedure.

Patient/Legal Representative Signature: _____

Patient's Printed Name: _____ Date: _____

Physician Signature: _____

