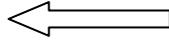


Greg S. Cohen, MD

GI Lab Address

259 East Erie Street, Lavin Family Pavilion



go here for the procedure

16th Floor Reception Area

Chicago, IL 60611 312-695-4452

Outpatient Anorectal Manometry Instructions

Please read carefully all the instructions TODAY and at least one week before your procedure and follow the instructions exactly. Failure to do so may result in the need to reschedule your procedure. If you have questions please call 312-926-2425 Monday – Friday, 8:00 am – 4:00 pm. **If you need to cancel, please call with at least 72 hours notice.**

ABOUT ANORECTAL MANOMETRY

Anorectal Manometry is a test used to assist your physician in the diagnosis and treatment of various rectal disorders such as incontinence and constipation. Anorectal Manometry allows your physician to measure the pressure in the rectum and in the anal sphincters to show how strong the sphincter muscles are and whether they relax as they should when having a bowel movement. It also measures the ability to perceive sensations of fullness in the rectum.

ANORECTAL MANOMETRY PREPARATION

- Before your test, the GI lab nurse will review your medical history, allergies, and current medications. Please complete the patient questionnaires which are attached to this packet and bring them with you to the GI lab on the day of your test.
- You will need to administer 2 Fleet's enemas (available without a prescription over-the-counter) 2 hours before the test. The rectum needs to be clear of stool to perform an accurate test.
- There are no eating or drinking restrictions prior to the Anorectal Manometry. However, you may wish to eat a light breakfast and/or lunch on the day of your test.

DURING THE ANORECTAL MANOMETRY

Anorectal Manometry takes about **15 minutes to complete**. The physician will explain the test and ask you several questions related to the symptoms that you have been experiencing. Then you will be asked to lie on your left side. The physician will perform a rectal exam before starting the Anorectal Manometry test. A thin catheter, which is a flexible plastic tube about the size of a drinking straw will be inserted into the rectum to perform the test. The Anorectal Manometry catheter has a small balloon at the tip which is filled with air. During the test, pressure measurements will be taken. The catheter may be moved around slightly to ensure proper positioning.

During the test you may experience some rectal pressure and/or a feeling of having to have a bowel movement. The physician or technician will ask you to squeeze, relax, and push during the test. During these exercises, the anal sphincter muscle pressures are measured. When squeezing, you will tighten your sphincter muscles as if trying to prevent yourself from having a bowel movement. When pushing, you will bear down as if trying to have a bowel movement. You will also be asked during these exercises if you notice any rectal sensations. In some cases a balloon expulsion test may be performed in which a small balloon at the end of the Anorectal Manometry catheter is inflated and you are asked to try to push the catheter out. Once the Anorectal Manometry is completed, the catheter will be removed and your test will be finished.

AFTER THE ANORECTAL MANOMETRY

The Anorectal Manometry test is usually well tolerated with no serious problems or side effects. Unless instructed otherwise by your physician, after the test, you may resume all normal activities. Your physician will receive the test results usually within 4 business days and will discuss the results with you.

GI LAB PATIENT QUESTIONNAIRE

Refer to Reminder below before completing this form. Thank you for choosing Northwestern Memorial Hospital for your GI Lab procedure. **Please fill out this form and bring it with you the day of the procedure.** Please answer each question. This allows us to provide you with the best possible care.
(Please print)

Patient Name _____ Date of Birth _____ Date of Procedure _____

Name of Primary Care Physician _____ Fax Number _____

Address _____ Phone Number _____

Procedure and Related Information: * Procedure normally requires sedation

- | | |
|--|--|
| <input type="checkbox"/> Flexible Sigmoidoscopy | <input type="checkbox"/> ERCP* |
| <input type="checkbox"/> Colonoscopy* | <input type="checkbox"/> Liver Biopsy* |
| <input type="checkbox"/> Upper Endoscopy (EGD)* | <input type="checkbox"/> Esophageal/Rectal/Small Bowel Manometry |
| <input type="checkbox"/> Endoscopic Ultrasound/Fine Needle Aspiration* | <input type="checkbox"/> 24-hour Ambulatory pH Study |
| <input type="checkbox"/> Other _____ | |

Reason for visit? _____

Please list the date of your last colonoscopy _____ (Month) _____ (Year)

Please list the date of your last upper endoscopy (EGD) _____

When was the last time you ate solid food? Date _____ Time _____

When was the last time you drank liquid? Date _____ Time _____

If your test required a bowel preparation, what preparation did you take? _____

Did you complete the preparation? Yes No—how much did you complete? _____

On the day of your procedure, will you have any of the following: *(Please circle)* Dentures, Removable Bridgework, Glasses, Hearing Aide, Walker, Cane, Wheelchair, Prosthetics, Other _____

Family/Friends/Transportation:

Who will be waiting for you during the procedure and/or taking you home afterwards?

Name _____ Relationship _____

Daytime contact number(s) _____

Verified by Admitting Nurse _____ Date _____ Time _____

Reminder: Per NMH Policy, after receiving any amount of sedation, you MUST have a responsible adult accompany you home after your procedure. You will not be discharged for any reason without an escort.

- If the admitting staff cannot verify your ride home, your procedure will be cancelled.
- You may not walk or take a cab/Uber/CTA home.
- You may not leave the GI Lab unaccompanied for any other appointments you have within NMH.

If your home is within the set service area of Superior Ambulance Company, you may make arrangements for them to take you home for an additional fee (contact Superior for pricing). If you would like to arrange this service, please call 312.926.5988 to make arrangements. Payment will be required at the time of service.

Do you take?

YES NO

- Sleeping or Anti-anxiety Medications, Sedatives
- Aspirin or Non-steroidal Anti-inflammatory Drugs

YES NO

- Prescribed Anticoagulants, Blood Thinners
Last Dose Taken (Date _____ Time _____)
- Insulin or pills to control your blood sugar

Past/Present History:

YES NO

- Are you currently experiencing pain? _____
Is your pain chronic? _____ Location _____
Please rate your pain – 0 (no pain) to 10 (worst pain) _____
- Have you or has anyone in your family ever had reactions to the medications given to you during any procedures or surgery? _____
Please describe _____
- Allergies (such as drug, food, latex): Please list _____
Reaction _____
- Have you experienced a fall in the last 12 months? Please describe _____
- Have you ever fainted, felt dizzy or nauseous after having your blood drawn or an IV started?
- Diabetes: If yes, do you take insulin or pills? _____
- Did you take your blood sugar level the day of your procedure? _____
Time taken and results _____
- High blood pressure: Is your blood pressure controlled by medication? _____
- Do you take antibiotics prior to medical or dental procedures? Antibiotic and dose _____
- Heart problems _____
- Heart pacemaker, implanted cardiac defibrillator _____
- Lung disease: (such as Asthma, Emphysema) _____
- Sleep apnea _____
- Cancer – Location _____
- Kidney disease _____
- Neurological problems: (such as seizures) _____
- Gastrointestinal disease or symptoms: (such as reflux, Crohn's Disease, ulcerative colitis) _____
- Liver disease: (such as cirrhosis, hepatitis) _____
- Glaucoma _____
- I smoke/use tobacco products. If NO: Do you have a history of use? (circle one) YES / NO
If YES or HISTORY: Amount per day _____ For how many years _____
- Alcohol/substance use: How much per day? _____ Last drink _____
- Have you had a hysterectomy? _____
For women ages 12–50, when was the first day of your last menstrual period? _____
- Are you pregnant or trying to become pregnant? _____
- Is there a possibility that you might be pregnant? _____
- Other (such as arthritis, blood disorders, HIV, infectious diseases, breast feeding) _____
- Do you follow a special diet for medical reasons? (For example, gluten-free) _____

Please list your surgeries _____

Patient Signature _____ Date _____ Time _____

Signature of Admitting Nurse _____ Date _____ Time _____

Reviewed by Physician Signature _____ Date _____ Time _____

