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 Colonoscopy Instructions – SUPREP

Your procedure is scheduled for _____, _____ .
Please arrive at _____am/pm in order to register prior to the exam.
Plan to spend 3 hours in the GI Lab from start to finish.

Diagnosis: _____

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 312-695-4452 Monday – Friday, 8:00 am – 4:00 pm. After hours, we can be reached at 773-884-2760. **If you need to cancel, you must call with at least 2 business days notice in order to avoid a "no show" fee.**

ABOUT THE COLONOSCOPY

This procedure is an endoscopic examination of the colon by a physician. A thin, flexible tube with a video camera at the tip is used to examine the colon. If necessary, a small piece of tissue (biopsy) can be removed for further examination under a microscope. If a polyp is found, it can generally be removed during the procedure**.** You will be given an intravenous line (I.V.) in the holding area. Immediately before the procedure begins you will receive I.V. medication for sedation. The test will take approximately 30 minutes to complete. You will be returned to the recovery area where you will be monitored for at least one hour after the procedure. Every effort will be made to keep your appointment at the scheduled time, but in medicine, unexpected delays and emergencies may occur and your wait time may be prolonged. We give each patient the attention needed for his or her procedure.

- You **may not** drive, operate machinery, make important decisions, or return to work for the remainder of the day following your procedure. You may resume normal activities the next day unless the doctor states otherwise.
- You **must have** a responsible adult to accompany you home after the procedure. This person must pick you up in the GI Lab. If you have another Doctor's appointment or any other testing at Northwestern Memorial Hospital after your GI Lab procedure, a responsible adult must escort you out of the GI Lab and to your appointment.
- You **may not** walk, take a taxi, or any public transportation home unless you are accompanied by a responsible adult.
- If our staff cannot confirm that you have made safe plans for discharge after your procedure, your procedure will be cancelled.
- If you will need assistance getting home after your GI Lab procedure, you can arrange a ride home with **Illinois Medi Car** through Superior Ambulance Company by calling **630-832-2000.** Payment for the transport must be provided prior to or at time of service and can be made over the phone at 630-832-2000. The base rate is $30 and the per mile rate is $3. If you have made Illinois Medi Car arrangements for your discharge home, please inform the GI Lab staff on the day of your procedure.

<u>It is your responsibility to check with your insurance company to see if they require authorization prior to performing the procedure, and if required you must forward any insurance forms to our office</u>. You should also double check that both Dr. Cohen and Northwestern Memorial Hospital are in your insurance network. If your insurance company requires you to have a referral for your procedure, please bring it with you on the day of your procedure. If you have Medicare, an Advance Beneficiary Notice (ABN) will be presented to you. This form acknowledges that Medicare <u>may deny</u> payment for the colonoscopy which could cause you to become responsible for the cost of the procedure. Please contact Medicare directly with further questions 800-633-4227.

REGARDING MEDICATION

If you are affected by any of the conditions listed below, please follow these instructions carefully.

Diabetes	Check with your physician regarding your dose of insulin and other diabetic medications needed the day before and the day of your procedure. Inform your doctor that you will be on clear liquids the day prior to your procedure. Check your blood sugar frequently while taking the prep solution and the morning of your procedure.
Heart Valve Replacement or History of Endocarditis	Prophylactic antibiotics are no longer recommended for GI procedures according to the guidelines published by the American Heart Association in 2007.
Blood Thinners: Coumadin, Plavix, Pradaxa, Xarelto, Eliquis, Savaysa, Brilanta, Effient, Lovenox	Ask the physician who prescribed your medicine how to take it before and after your procedure. If you cannot contact your physician, call us several days before your exam. If you take Coumadin, you may need a blood test two hours before your exam.
Iron Supplements	It is desirable that iron supplements be held for five days prior to your procedure.

RISKS OF COLONOSCOPY

Although colonoscopy is a safe test, there are inherent risks with all medical procedures. These risks include, but are not limited to: 1) Risk of anesthesia reactions including cardiopulmonary complications. 2) Bleeding. 3) Perforation or puncture of the colon – a rare complication that occurs once in every several thousand procedures. 4) Possibility of an incomplete exam in 1-2% of patients. 5) Possibility of missed or incompletely removed polyps. Although colonoscopy is the best test for detection and removal of polyps, it is not perfect. It is possible for polyps to be missed.

ONE WEEK BEFORE YOUR COLONOSCOPY

For best outcome, avoid eating foods that contain seeds, nuts, hulls, berries, or kernels (such as popcorn, poppy seeds, tomatoes, cucumbers, etc.). However, this instruction is not critical.

TWO DAYS BEFORE YOUR COLONOSCOPY

If you are constipated (i.e. bowel movements every 2-3 days or longer), it is recommended that you drink 10 ounces of Magnesium Citrate laxative two days before the colonoscopy so that the preparation on the day before the colonoscopy is easier and more effective. Magnesium Citrate is available without a prescription at any pharmacy. If you have kidney problems or are on dialysis, do not take Magnesium Citrate.

SUPREP PREPARATION INSTRUCTIONS:

DAY BEFORE YOUR COLONOSCOPY

1. **Today you may eat LOW RESIDUE solid food until 1 pm and then NOTHING BUT CLEAR LIQUIDS AFTER 1pm. Please drink plenty of fluids.**
    - Low residue foods include lean meats or ground meats, chicken, turkey, eggs, Egg Beaters, fish, white bread, pita bread, corn flakes, Rice Krispies, white rice, corn or flour tortillas, white potatoes without the skins, saltines, and pretzels.
    - **YOU CANNOT EAT:** fruits, vegetables, legumes, seeds, nuts, milk, juices with pulp, oatmeal, cream of wheat, muffins, bran, whole grains, granola, or raisins.
    - Clear Liquids include: water, coffee or tea without milk, strained fruit juices without pulp (apple, white grape, cranberry, etc.), carbonated beverages or soda pop, clear broth or bouillon. You may have plain Jello or Popsicles. You may have clear hard candy or gummy bears. If you are diabetic, please follow your usual dietary restrictions with regard to the liquids listed above.

2. **IF YOU ARE SCHEDULED FOR A MORNING COLONOSCOPY**
   Around 5 pm, do the first half of the prep:
    a. Pour ONE 6-ounce bottle of SUPREP liquid into the 16 ounce mixing container in the kit.
    b. Add cool drinking water to the 16-ounce line on the container and mix.
    c. Drink all the liquid in the container
    d. You must drink TWO more 16-ounce containers of water over the next 1 hour.

   Around 10 pm-midnight (the later the better) do the second half of the prep:
    a. Pour ONE 6-ounce bottle of SUPREP liquid into the 16 ounce mixing container in the kit.
    b. Add cool drinking water to the 16-ounce line on the container and mix.
    c. Drink all the liquid in the container
    d. You must drink TWO more 16-ounce containers of water over the next 1 hour.

3. **IF YOU ARE SCHEDULED FOR AN AFTERNOON COLONOSCOPY**
   Around 5 P.M., do the first half of the prep:
    a. Pour ONE 6-ounce bottle of SUPREP liquid into the 16 ounce mixing container in the kit.
    b. Add cool drinking water to the 16-ounce line on the container and mix.
    c. Drink all the liquid in the container
    d. You must drink TWO more 16-ounce containers of water over the next 1 hour.

   Approximately 5-6 hours prior to your scheduled arrival time do the second half of the prep:
    a. Pour ONE 6-ounce bottle of SUPREP liquid into the 16 ounce mixing container in the kit.
    b. Add cool drinking water to the 16-ounce line on the container and mix.
    c. Drink all the liquid in the container
    d. You must drink TWO more 16-ounce containers of water over the next 1 hour.

4. In order to perform a successful colonoscopy, the colon must be cleaned of fecal material. This is accomplished using this preparation and will stimulate your colon to purge itself, and result in many trips to the bathroom. You will probably start to have a bowel movement within 1 to 2 hours of drinking the laxative. The laxative may cause cramping and rapid elimination of stool.

5. Do not eat or drink anything after Midnight except the colonoscopy prep and your usual medications. You may brush your teeth, and have small sips of clear liquids until 3 hours before your procedure.

WHAT TO EXPECT ON THE DAY OF YOUR COLONOSCOPY

- You may brush your teeth, and have small sips of clear liquids until 3 hours before your procedure.
- You may take your usual medications with small sips of water. If you use inhalers, prescription eye drops or nasal sprays, you may take them as you would normally and then bring them with you.
- Please bring your **completed** GI LAB PATIENT QUESTIONNAIRE and MEDICATION LIST with you (see the last 3 pages of these instructions).
- If you have a colostomy or ileostomy, please bring an extra set of stoma supplies (flange, pouch, etc.) so that your stoma pouch can be replaced following the procedure.
- Wear comfortable clothing that is easy to remove and **leave jewelry and any other valuables at home**.
- Please limit your visitors to 1 or 2 friends or family members. Please speak with one of the GI Lab staff members if you have a special circumstance or request.
- Parking is available in the Lavin Family Pavilion and can be accessed from either Erie Street or Ontario Street. Remember to bring your parking ticket with you for validation.
- Report to the GI Lab on the 16th Floor of the Lavin Family Pavilion to check in at the registration desk at the arrival time scheduled by your Doctor's office.
- You will be required to show a photo ID, verify insurance information, address, phone number, and e-mail address.
- If you are concerned that you have been waiting too long after you have checked in, please speak to the front desk staff or a GI Lab staff member.
- You will be brought into the GI Lab where a nurse will review your medical history, current medication list, and that you have taken your preparation appropriately. You will be asked to put on a hospital gown. An intravenous line (IV) will be started for your sedation during the procedure. If you are female, you will be offered a free pregnancy test prior to the procedure, per hospital policy. If you have a history of falling or fainting, please tell the nurse before the IV is placed.

You may be waiting in a gowned waiting room prior to your procedure with other patients. There are many doctors that perform procedures in the GI Lab and many patients that are having a variety of procedures. If you have any concerns about a delay or your exact procedure time, please speak with one of the GI Lab staff members.

- During the procedure, your heart rate, blood pressure and oxygen level will be monitored.
- You will be required to sign a consent form with the doctor prior to your procedure.
- When your procedure is done, you will remain in the recovery room for **at least** 1 hour.
- You may still experience effects from the sedation, such as being tired and forgetful, for a few hours after your procedure.
- The recovery room nurse will review what you should expect to feel for the remainder of the day. If you had a colonoscopy, this includes feeling some gas pain. If you have had an upper endoscopy, you may have a sore throat.
- After the procedure, you will receive preliminary results and follow-up instructions.
- When you leave the GI Lab, please remember to take all of your belongings and your discharge instructions.
- About 3 days after your procedure, you will receive a patient satisfaction form via e-mail. Please complete this, as your feedback is valuable to our operation.

Please let us know if you will require special assistance while you are in the GI Lab for your procedure. This includes having difficulty with starting IV's, requiring a language interpreter, requiring assistance with walking, changing clothing, or any other special request please contact the GI LAB Clinical Coordinator at 312-926-7614.

Northwestern Medicine®

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**

- ☐ Flexible Sigmoidoscopy
- ☐ Colonoscopy*
- ☐ Upper Endoscopy (EGD)*
- ☐ Endoscopic Ultrasound/Fine Needle Aspiration*
- ☐ ERCP*
- ☐ Liver Biopsy*
- ☐ Esophageal/Rectal/Small Bowel Manometry
- ☐ 24-hour Ambulatory pH Study
- ☐ 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.

→ Complete both sides of form

Do you take?

YES	NO		YES	NO	
☐	☐	Sleeping or Anti-anxiety Medications, Sedatives	☐	☐	Prescribed Anticoagulants, Blood Thinners Last Dose Taken (Date _____ Time _____)
☐	☐	Aspirin or Non-steroidal Anti-inflammatory Drugs	☐	☐	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** _____

Northwestern Memorial® Hospital

GI LABORATORY
At-Home Medications List

Dear Patient,
Please complete the Allergies and Medication sections. A staff member will review this list with you if there are any questions.
If you have questions about medications NOT prescribed during today's visit, please contact your primary care physician.

ALLERGIES: ☐ None (check the box if you do not have any allergies)

Source	Reaction	Source	Reaction
Example: Penicillin	*Hives*	3.	
1.		4.	
2.		5.	

MEDICATIONS: ☐ None (check the box if you do not take any medications, vitamins, herbals, etc) Physician/Staff Use

DRUG List the medications you are taking, include all over-the-counter medicines, vitamins, herbals, minerals, and those you may have held for today's visit.	**STRENGTH** List the strength of each tablet, capsule, etc.	**DOSE/ DOSE FORM** How many tablets, units, capsules, are you taking at one time?	**FREQUENCY** How often do you take the medication? (once a day, twice a day, etc.)	**ROUTE** How are you taking this medication? (by mouth,injection, patch, etc.)	**LAST DOSE TAKEN** Indicate the date and time you last took the medication	***Physician:*** **Please check if prescribing additions or changes to chronic medications** ***Staff:*** **If checked, refer to Instructions below. If not checked, file list**
Ex. Cardizem CD	*180 mg*	*1 capsule*	*once a day*	*by mouth*	*9 pm last night*	☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐

Date:_____

Do not write below this line - Hospital Staff ONLY

INSTRUCTIONS:
Staff: If, during this visit, the patient was prescribed a new medication for a chronic disease/condition or a change was made to the at-home medication regimen for a chronic disease/condition, complete the patient instructions portion below, instruct the patient regarding additions and/or changes, and provide the patient with a photocopy of this document. After completion, check box below, and file.

☐ Medication instructions were reviewed with the patient. The patient received a photocopy of this medication list.

Patient: START/RE-START taking this at-home medication(s):

Condition Medication is prescribed for:	Take this Medication at this Strength:	At this Dose/Dose Form:	How often: (Frequency)	Route:	Start taking this Medication on:	Date, if any, you should **stop** taking this medication:
					___/____/____	
					___/____/____	

Patient: STOP taking this at-home medication:

STOP taking this Medication at this Strength, Dose/Dose Form, and Frequency: _____

STOP taking this Medication on:_____ /_____ /_____

Additional Comments: _____

420609