

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 Flexible Sigmoidoscopy (Flex Sig) Instructions

Your procedure is scheduled for _____, _____ .
Please arrive at _____ am/pm in order to register prior to the exam.
Plan to spend 1 hour in the GI Lab from start to finish (2 1/2 hours if you are sedated).

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 FLEXIBLE SIGMOIDOSCOPY

This procedure is an endoscopic examination of the left side of your 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, you may need to be rescheduled for a complete colonoscopy in order to remove it. The test will take approximately 15-20 minutes to complete. 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. This test is usually performed with no anesthesia, but I.V. sedation can be given if special arrangements are made ahead of time (see below).

IF IV SEDATION IS USED FOR THE 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.

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. You should also check that Northwestern Memorial Hospital is 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.

REMINDER

You need to purchase your 3 Fleet enemas. This item is available at your local pharmacy or can be purchased in the hospital pharmacy.

ONE WEEK BEFORE YOUR SIGMOIDOSCOPY

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.

DAY BEFORE YOUR SIGMOIDOSCOPY

1. On the evening before the test, eat a clear liquid supper. Clear liquids include water, black coffee, tea with sugar, clear broth, bouillon, and clear juices such as apple or cranberry juice (no juices which contain pulp), ices, popsicles, and plain jello.
2. Before going to bed, give yourself one Fleet enema. Please follow the instructions on the box. It is important to try and hold the fluid for at least 10 minutes before emptying your bowel.

DAY OF YOUR FLEXIBLE SIGMOIDOSCOPY

1. On the morning of the examination, one or two hours before your appointment, give yourself the 2 remaining Fleet enemas. Take one, holding the fluid for at least 10 minutes. Expel the fluid and stool and repeat the process with the final enema. It is important to retain the fluid for 10 minutes to allow the bowel to be cleansed.
2. Eat a clear liquid breakfast. If your appointment is in the afternoon, you may continue on clear liquids until your appointment time.
3. Medications: You may take any early morning medications. If you take insulin, please check with your doctor about dosage adjustment for the day before the procedure and the day of the procedure. Please check your blood sugar at home before coming for the test.
4. After arriving at the hospital, make one more attempt to empty your bowel.

WHAT TO EXPECT ON THE DAY OF YOUR FLEXIBLE SIGMOIDOSCOPY

- You may brush your teeth, but do not swallow any water.
- 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 (only if sedation is used – otherwise you will be discharged shortly after the procedure).
- You may 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. This includes feeling some gas pain.
- 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.

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 _____

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
<i>Example: Penicillin</i>	<i>Hives</i>	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
<i>Ex. Cardizem CD</i>	<i>180 mg</i>	<i>1 capsule</i>	<i>once a day</i>	<i>by mouth</i>	<i>9 pm last night</i>	<input type="checkbox"/>
						<input type="checkbox"/>
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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: _____

