

**NEW ENGLAND CONSULTANTS IN GASTROENTEROLOGY & HEPATOLOGY**  
**43 LINCOLN STREET**  
**FRAMINGHAM, MA 01702**  
**PHONE: (508) 872-0508 FAX: (508) 872-0588**

**KHALID AZIZ, MD**

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**ENDOSCOPY INSTRUCTIONS**

PLEASE READ THE MATERIALS IN THIS PACKAGE AS SOON AS YOU GET THEM-DO NOT WAIT UNTIL THE DAY OF YOUR TEST.

This is important because some of preparation may begin as early as one week before the day of your test.

You are scheduled for a Upper Endoscopy/ Gastroscopy (EGD) on: \_\_\_\_\_ at \_\_\_\_\_.

Please report to the location checked below one hour early at: to the hospital 30 minutes early. at \_\_\_\_\_ except Saint Vincent Hospital report

☐ **MetroWest Medical Center**

115 Lincoln Street  
1st Floor Endoscopy Dept.  
Framingham, MA 01702

☐ **Nashoba Valley Medical Center**

200 Groton Road  
1st floor Registration  
Ayer, MA 01432

☐ **Saint Vincent Hospital**

123 Summer Street  
2nd Floor Suite 240 South  
Worcester, MA 01608

☐ **Worcester Surgical Center**

300 Grove Street  
1st Floor Registration  
Worcester, MA 01605

☐ **Harrington Hospital**

100 South Street  
1st floor Lobby Registration  
Southbridge, MA 01550

It is extremely important that you make arrangements to have a responsible adult available to take you home after your procedure. You may not drive yourself home after the test. If you take a cab, someone must ride home with you in the cab (additional to the cab driver). This is a policy that is strictly enforced for your safety. **NO EXCEPTIONS.**

**THERE ARE SOME VERY IMPORTANT FACTS THAT YOU NEED TO BE AWARE OF:**

1. If you take Coumadin, Warfarin, Plavix, Clopidogrel or Effient, it will need to be discontinued 5 days before procedure.
2. If you take Pradaxa, Eliquis, Xarelto, or Aggrenox, it will need to be discontinued for 2 days before procedure.
3. If you take Lovenox, it will need to be discontinued 24 hours before procedure.
4. If you have Diabetes, preparing for a procedure involves some temporary changes in your diet. It is important that you know how to adjust your insulin or your oral medicines during this time.
  - ❖ If you take oral diabetes medication, should not take it the day before or the night before your procedure. Please consult with your doctor when to resume your oral diabetes medication after your procedure.
  - ❖ If you take Insulin, you **MUST** consult with the doctor who takes care of your diabetes for any temporary changes to your insulin dosing.
5. You should continue taking all other regular medications, even on the day of the examination. If you have any questions, please call the office at (508) 872-0508.

**PREPARATION FOR ENDOSCOPY (EGD):**

- ❖ No solid food or thick liquids after midnight (the night before your test). You may have **CLEAR LIQUIDS** only up to 6 hours prior to your procedure. If you do not stop clear liquids 6 hours prior to your procedure, your procedure may be delayed or cancelled.
- ❖ The following items may be used as **CLEAR LIQUID** diet: Broth, Bouillon, Ginger Ale, Sprite, 7-up, Apple Juice, White Grape Juice, Water, Popsicles (no red or purple colored, no fruit or cream added), Black coffee or tea (no milk or cream).

- ❖ The examination will take approximately 30 minutes, but this may vary from patient to patient. After the examination is completed, you will spend SURGICAL DAY CARE PRE-PROCEDURE ASSESSMENT approximately one hour in the recovery area.
- ❖ Please keep in mind that this is an estimated appointment time. Because the time involved in each procedure is often unpredictable, and procedures are scheduled to follow each other consecutively; there are occasions when the schedule runs behind. Your patience and understanding are appreciated.

**DAY AFTER EXAMINATION:**

You can expect to resume normal activities again unless otherwise indicated. After the procedure, you will be given instructions about diet and medications.

**APPOINTMENT CANCELLATION POLICY:**

A \$250.00 cancellation fee will be billed directly to the patient for any appointment not cancelled with a 72 hours notice.

PLEASE CALL THE OFFICE TO CONFIRM YOUR PROCEDURE 3 DAYS PRIOR. FAILURE TO CALL IN A TIMELY MANNER, YOUR SCHEDULED TIME MIGHT BE SUBJECT TO CHANGE.

•If you are unable to keep your appointment, please call within 72 hours of your appointment time TO CANCEL OR RESCHEDULE. If appropriate, we may accommodate other patients who are waiting.

**\*\*\*PROCEDURE TIME IS SUBJECT TO CHANGE\*\*\***

**A hospital staff will be calling you to pre register and confirm your insurance information. You still need to call our office to confirm procedure.**

## SURGICAL DAY CARE

### PRE-PROCEDURE ASSESSMENT

Please review the instructions from your Doctor's office. You must have a ride home with a responsible adult; taxi with a responsible adult (not taxi driver) allowed. Do not bring money, jewelry or valuables with you. Please bring this form and insurance cards the day of your procedure.

Person Driving You Home: \_\_\_\_\_

Phone Number \_\_\_\_\_

Personal Medical History (Self)	YES	NO	Explanation (if yes) and year
Heart attack, angina, murmur, valve replacement, implanted pacemaker or defibrillator			
High Blood Pressure			
Anemia, bleeding or clotting problems			
Breathing or lung problems			
Sleep apnea			
Seizures or strokes			
Hepatitis, liver or kidney disease			
Cancer			
Diabetes			
Thyroid problems			
Arthritis, limited movement, pain			
Diarrhea/Constipation			
Trouble swallowing, heartburn			
Smoke or drink alcohol (amount)			
Recreational drugs (type and amount)			
Pregnant or nursing			
Other medical problems			

Height \_\_\_\_\_ Weight \_\_\_\_\_ Loss of more than 5 lbs in past month?

TURN OVER TO CONTINUE

**MEDICATIONS**

Please list any prescriptions you are taking regularly as well as over the counter medicines (such as herbal supplements, vitamins, aspirin, laxatives etc.).

<b>Medicines</b>	<b>Dosage(amount)</b>	<b>How Often</b>	<b>Last Dose</b>

Do you have any allergies? (medicines, foods, latex or seasonal)

Describe:

Past surgeries and when:

Have you ever been hospitalized for any other reason?

Have you had any problems with anesthesia or sedation in the past?

The RN has seen the patient and reviewed the pre-procedure assessment form.

Signature\_\_\_\_\_Date/Time\_\_\_\_\_