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

KHALID AZIZ, MD **ANNIE T. CHEMMANUR, MD**

PREPARATION FOR FLEXIBLE SIGMOIDOSCOPY/RECTAL EUS

You are scheduled for a Sigmoidoscopy/Rectal EUS on Date: _____Hospital Arrival:_____
Time: _____with Provider: Khalid Aziz, MD Annie T. Chemmanur, MD

_____ MetroWest Medical Center-115 Lincoln Street 1st Floor Endoscopy Dept.-Framingham, MA

_____ Marlborough Hospital-157 Union Street-Central Registration 1st Floor- Marlborough, MA

_____ Nashoba Valley Medical Center-200 Groton Road 1st Floor Registration-Ayer, MA

_____ St. Vincent Hospital-123 Summer Street 2nd Floor Suite 240 South-Worcester, MA

_____ Harrington Hospital-100 South Street 1st Floor Lobby Registration-Southbridge, MA

YOUR PROCEDURE SHOULD TAKE PLACE APPROXIMATELY 1 HOUR AFTER YOU CHECK-IN.
*******PLEASE ADVICE THE OFFICE IF YOU HAVE LATEX ALLERGY******
THERE ARE SOME VERY IMPORTANT FACTS THAT YOU NEED TO BE AWARE OF:

1. STOP BLOOD THINNER ACCORDING TO THE LIST: Please inform the prescribing Physician prior to stopping them.

Coumadin/Warfarin/Plavix/ Effient-	5 DAYS BEFORE PROCEDURE
Aspirin, Ibuprofen, Excedrin, Aleve-	4 DAYS BEFORE PROCEDURE
Eliquis/Aggrenox/Xarelto/Pradax-	48 HOURS BEFORE PROCEDURE
Lovenox-	24 HOURS PRIOR TO PROCEDURE

2. Please inform us if you take Insulin. It may need to be altered for the procedure as follow: DAY BEFORE PROCEDURE: regular insulin dose in AM, and 1/2 insulin dose at PM (MAKE SURE TO CHECK YOUR BLOOD SUGAR 2-3 TIMES DAY BEFORE PROCEDURE.

3. STOP taking any Diabetes medications the day of procedure.

4. You should continue taking all other regular medications, even on the day of the exam. Any questions please call the office at (508) 872-0508.

5. You must have a family member or a friend drive you home after the examination due to the medications that are given during the procedure. The SIGMOIDOSCOPY /Rectal EUS CANNOT be done unless you have arranged for someone to accompany you when you leave the hospital. You cannot take a Taxi unless accompanied by someone other than the taxi driver.

6. Please complete the Pre-Procedure Assessment Form Enclosed and bring it with you to the hospital on the exam day.

IF YOU CANNOT KEEP THE APPOINTMENT PLEASE CALL THE OFFICE WITHIN 72 HOURS NOTICE AT (508) 872-0508 (WEEKEND AND HOLIDAY DOES NOT COUNT). AFTER 72 HOURS A $250.00 CANCELLATION FEE WILL APPLY.

Flexible Sigmoidoscopy Preparation Instructions

It is very important that the following preparation is followed exactly as outlined.

Day before the procedure:

- You need to follow a clear liquid diet ALL DAY - no red or purple liquids. No solid foods, milk or milk products.Choices:

  Apple juice

  Sprite

  Ginger ale

  Fresca

  Tea and coffee (honey, sugar, sugar substitutes ok - no milk)

  Jell-O (no red or purple)

  Popsicles (orange, lemon-lime)

  Vitamin Water or Gatorade (orange, lemon-lime)

  Clear soup, broth (vegetable, beef or chicken) White grape juice

  Hard candy

(NIGHT BEFORE)

1. CLEAR LIQUIDS ALL DAY
2. 2 PACKETS OF MIRALAX AT 6:00PM
3. 2 PACKETS OF MIRALAX AT 8:00PM
4. NPO (NOTHING TO EAT OR DRINK) AFTER MIDNIGHT

(DAY OF PROCEDURE)

1. ONE FLEET ENEMA 3 HOURS BEFORE PROCEDURE
2. ONE FLEET ENEMA 1 HOUR BEFORE 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 lists any prescriptions you are taking regularly as well as over the conter medicines (such as herbal supplements, vitamins, aspirin, laxatives etc.).

Medicines	Dosage(amount)	How Often	Last Dose

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_____