Harmony SURGERY CENTER

Center for Gastroenterology
Specialists in Digestive Health

Upper Endoscopy (EGD)

Your procedure is scheduled on: ________________(Date)

Please check in at the Reception desk at __________. Your procedure is scheduled for ___________.

Pre-Procedure Information:

To schedule your procedure, please call Centers for Gastroenterology at 970-207-9773

- ***Harmony Surgery Center is located at***:
  2127 East Harmony Road, Suite 200
  Fort Collins, CO 80528
  If you need directions to our facility, please visit our website at www.harmonyasc.com

- ***Please Remember***
  - ***You must have a driver to take you home. Your driver will need to be 18 years of age or older and must be willing to sign you out as your responsible party. You will not be permitted to drive or take a cab home after the procedure. You are not allowed to drive until the next day. If you do not have a driver your appointment will be cancelled.***
  - Please leave all jewelry and valuables at home.
  - Please bring your **Insurance Card** and a **Photo ID** (driver's license, passport or military ID).
  - If you need to cancel or reschedule your procedure for any reason, please call our scheduling department at 970-207-9773. If you cancel with less than one weeks' notice, you may be charged $250.00 from ***Harmony Surgery Center***. If the cancellation is within a 72-hour notice before your procedure you may also be charged a $300.00 cancellation fee from your physician's office - ***The Centers for Gastroenterology***.

General Information:

- If you have any questions, please call Harmony Surgery Center at 970-297-6303. If you have an urgent request ***after hours***, please call 970-207-9773 and the gastroenterologist on-call can assist you.
- Take your medications as you normally would up until 4 hours before your procedure.

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Upper Endoscopy (EGD) PREP

To get the best results from your Upper Endoscopy and to avoid having to do the procedure over, please follow these instructions completely unless directed otherwise by your physician. Please take your insulin or blood thinner products as you were directed by your GI physician during your office visit. If you have questions, please call us at 970-297-6303.

Time line	What you need to do	Comments
7 days before procedure	☐ Arrange for a responsible adult to come with you into the facility on the day of your procedure to listen to your discharge instructions and drive you home. You may NOT take a cab or public transportation. You will not be allowed to drive until the day following your procedure. ☐ **IF YOU TAKE BLOOD THINNER PRODUCTS:** follow the specific instructions for your blood thinner as instructed by the Coumadin Clinic or your GI Physician. If you have not received specific instructions **1 week prior** to your appointment, please call the Centers for Gastroenterology at 970-207-9773. ☐ **IF YOU TAKE INSULIN PRODUCTS OR ORAL DIABETES PILLS,** please see the enclosed diabetic instruction sheet.	For your safety, your procedure will be cancelled if you do not have a ride home arranged. You may take Tylenol® if necessary
Day before your procedure:	☐ If your exam is before 12:00 noon, please fast after midnight (nothing to eat or drink). ☐ If your exam is after 12:00 noon, do not eat after midnight, but you may drink clear liquids until 4 hours prior to your procedure. Clear liquids include: ○ Chicken or beef bouillon/broth ○ Coffee or tea without cream ○ Pulp-free fruit juices (apple, white grape) ○ Sport drinks like Gatorade® ○ Jello® (not red, blue, or purple) ○ Clear sodas (Sprite®, 7Up®, ginger ale)	DO NOT drink or eat anything that is RED, BLUE, or PURPLE.
Day of procedure: **4 hours before**	☐ Take your usual medications (especially heart and blood pressure medications) **up to 4 hours prior to the procedure.** It is OK to take aspirin up to and including the day of the procedure, up to 4 hours prior to your procedure. **Follow specific directions given by your physician regarding insulin, oral diabetes pills, and blood thinners.** ☐ **Do not drink or eat anything until after your procedure is complete, including NO gum, mints, candy or chewing tobacco**.	
Appointment time	☐ Please arrive 1 hour before your scheduled procedure time with your responsible adult companion.	For your safety, your procedure will be cancelled if you do not have a ride home arranged.

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2127 E Harmony Rd. Ste. 200 Fort Collins, CO 80528

Consent for Upper Gastrointestinal Endoscopy
Informative copy only – Please do not fill out

I,__________________, permit Dr.__________________and any other assistant needed in performing the procedure my doctor has recommended. The procedure my doctor has recommended is an UPPER GASTROINTESTINAL ENDOSCOPY which is defined below and may include any of the following:

- Upper Gastrointestinal Endoscopy: Examination of the esophagus, stomach, and duodenum with a flexible tube which is passed through the mouth.
- Biopsy: Removal of small pieces of tissue from within the intestine for analysis.
- Polypectomy: Removal of small growths from within the intestine.
- Dilation: To enlarge a narrow area.
- Electrocautery/Injection/Sclerotherapy/Band Ligation: Use of heat, chemicals, rubber bands to stop bleeding.
- Removal of Foreign Body.

Benefits of upper Gastrointestinal Endoscopy include but are not limited to the following: The lining of the esophagus, stomach and duodenum are surveyed for inflammation, tumors, polyps, strictures or areas of narrowing, foreign bodies and bleeding sites.

Alternatives to Upper Gastrointestinal Endoscopy include: Doing no testing, the upper gastrointestinal tract being alternatively viewed by barium enema x-ray and if abnormal one would require an upper endoscopy, or a surgical procedure.

Risks associated with Upper Gastrointestinal Endoscopy:

1. These are very accurate procedures, but with any medical test, there is a small chance of missing something.
2. The major complications associated with an Upper Endoscopy include:
   - Perforation (making a hole), which would require admission to the hospital and surgery for the correction of the perforation.
   - Bleeding – particularly if a biopsy is taken or a polyp is removed;
   - Heart or lung problems, aspiration, pneumonia;
   - Reaction (allergy) to medications;
   - Dental injury including chipped teeth; and
   - Damage to existing dentition or prior dental work can occur.
3. Any procedure which involves anesthesia/sedation has some risks.

I consent to the administration of intravenous medications during this procedure. The primary intent of administering this medication is to produce a state of relaxation while still being able to breath easily, swallow, answer questions and follow simple commands. You may lose consciousness and possibly be fully or partially immobilized. Recall of events during this procedure may also occur. The administration of medication carries some risk of complication. Few complications occur, most are minor and last only a short time. Some of the complications that rarely occur are: over sedation, low blood pressure, slow or ineffective breathing, pneumonia, and prolonged recovery time. Should any complication arise, both the physician directing the administration of these medications and the anesthesia provider who are with you are prepared and trained to intervene with the necessary treatment.

- It has been explained to me that during the course of the procedure, unforeseen conditions may be revealed that necessitate an extension of the initial procedure or a different procedure than set forth above. I therefore authorize and request the above named physician or his designated consultants perform such procedures that are in his judgment necessary and desirable.
- I consent to the study and retention or disposal of tissue parts that may be removed during the above procedure.
- I consent to the presence of observers in the operating room, such as students, medical residents, medical equipment representatives, or other appropriate parties approved by my physician(s). Medical students may participate in my surgical care under the direct supervision of my physician(s).
- I consent to the presence of observers in the operating room, such as students, medical residents, medical equipment representatives, or other appropriate parties approved by my physician(s). Medical students may participate in my surgical care under the direct supervision of my physician(s).
- I consent to the taking of photographs (including motion pictures) and the preparation of drawings and similar illustrated graphic material, and I also consent to the use of such photographs and other materials for scientific purposes in accordance of this institution.

Your physician and anesthesia provider are not employees of the Center; they are agents of you. The Surgery Center is responsible for and provides supportive nursing and procedural services. The Surgery Center is not responsible for actions of the physician or anesthesia provider.

I have had sufficient opportunity to discuss this procedure with Dr.______________________________and I understand the nature of the procedure, the possible benefits, risks (including need for surgery), and alternatives listed.

Allergies (medications, latex, products):

☐ None

Do you or your responsible party need information on the following (circle needs)? Medications Treatment/Procedures Current Illness Follow-up care Diet/Nutrition Hygiene/Grooming/Oral Care Home Care Community Resources Equipment

Preferred Learning Method (circle)? Listening Demonstration Reading Hands-on Other:

Barriers to learning or care (circle)? Cognitive Hearing Reading/Writing Language Culture Vision Emotional Physical Financial Religion Other:

Pain Evaluation: Current Pain? ☐ Yes ☐ No If yes: Pain level (1-10)________ Location:
Description (circle): Dull Sharp Burning Aching Current pain treatment:

Please list any belongings you have with you:
Note: HSC is not responsible for belongings. Please give all valuables to your ride home.

Who is taking you home today? (note – you are advised to have a responsible adult with you for 24 hours after procedure):

Name of Ride: ____ **Phone Number:** ________________________________
**Prior to your discharge, do you grant our staff permission to go over procedural information, medications and discharge instructions with your ride? ☐ Yes ☐ No

Health History:	Yes	No
Seizure/stroke or other neurological problem? Describe:		
Problems with your heart? Describe:		
Chest pressure, chest pain?		
Shortness of breath with exertion or exercise?		
Pacemaker or defibrillator?		
Cardiac stent/blood vessel stent or cardiac bypass?		
High blood pressure?		
Blood thinner medication? Clotting problems?		
Take aspirin or aspirin-like meds (i.e., Motrin, Aleve, Ibuprofen, etc.)?		
Blood disorder? Describe:		
Autoimmune disorder? Describe:		
Lung problems or problems breathing? Describe:		
Do you currently smoke?		
Have you ever smoked? When did you quit?		
Supplemental oxygen?		
Sleep apnea? CPAP? Oxygen at night?		
Kidney problems?		
Gastrointestinal problems?		
Liver problems?		
Diarrhea or abdominal cramping? For how long?		
Thyroid, Parathyroid, or adrenal gland problems?		
Cancer treated with chemotherapy or radiation?		
Have you had surgery on any of the following? ☐Heart ☐Brain/Spine ☐Transplant ☐Implants		
Have you been hospitalized in the last 90 days?		

	Yes	No
Currently have a contagious or infectious condition? Describe:		
Illness, infection or fever in the past 2 weeks?		
Diabetes and/or high blood sugar?		
Taken steroids (i.e. Prednisone) in the last year?		
Suffer from anxiety, depression, panic attacks or PTSD?		
Used recreational drug(s) within the last 3 days?		
Smoked or consumed marijuana in the past 3 days?		
Drink alcohol? ☐ Daily ☐ Weekly ☐___________		
Dentures or problems with your teeth?		
Eye or vision problems?		
Hearing problems? ☐ Hearing Aids		
Use wheelchair, walker, cane, etc.?		
Frequent heartburn?		
Object to blood products under any circumstances?		
Problems with anesthesia (self or blood-relative)? Describe:		
Any concerns about anesthesia? Describe:		
Is there any possibility you could be pregnant? ☐N/A		
Currently breastfeeding? ☐N/A		

Date of your last menstrual period? ☐N/A

Do you have an Advance Directive: ☐ CPR Directive
☐ Living Will ☐ Power of Attorney ☐ Other

Who is your Primary Care Doctor?

Weight: **Height:**

Signature of patient or person completing form:

X

Medication Reconciliation Form

****Please list all medications on this form. We are NOT able to accept a copy of your medications****

Patient: Please list all medications taken on a regular basis (including over the counter and herbal preparations).

Medication Name	Dose	Route	Frequency	Last Taken	RN to complete: Continue after discharge OR refer to prescribing physician: CONTINUE	REFER to MD
1.					❑	❑
2.					❑	❑
3.					❑	❑
4.					❑	❑
5.					❑	❑
6.					❑	❑
7.					❑	❑
8.					❑	❑
9.					❑	❑
10.					❑	❑
11.					❑	❑
12.					❑	❑
13.					❑	❑
14.					❑	❑

New Prescriptions Prescribed at HSC	Dose	Route	Frequency	Last Taken	Use
1.					
2.					
3.					
4.					

I will be provided with a copy of this list upon discharge. Please note, all routine medications marked "REFER to MD" should be clarified with the prescribing physician before continuing. **Medication Safety:** To safely manage routine and new medications, it is important to give a copy of your Medication Reconciliation Form to your primary care physician. It is also important to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added.

Patient/Responsible Party Signature:______________________________ Date:______________________

RN Signature:___________________________Date:____

Important Billing Information…

As you prepare for your procedure, we want to make sure you understand how you will be billed for the services you receive. At a minimum, you will receive three separate bills. Depending on your specific procedure, you may also get additional bills.

Billing Sources…

- **Surgery Center's Bill:**
  You will get a bill from us for what is known as the facility fee. This fee is for staff, supplies, equipment and medications we provide for your safe and successful experience here.
- **Surgeon's Bill:**
  Since the physician performing your surgery is not an employee of the Center, you will be billed separately for these services. The physician's bill will be sent from the physician's office.
- **Anesthesia Bill:**
  Anesthesia is provided by Center's for Gastroenterology's team of Certified Registered Nurse Anesthetists. For questions about your anesthesia bill, please contact them directly at 970-207-9773.

Other Bills: Depending on several factors related to your procedure, you may receive services and additional bills which may include:

- **Laboratory Bill:** May include fees for blood or urine tests.

- **Pathology Bill:** - May include testing of any tissue samples taken during the procedure. Pathology results will be available from your physician's office **7-10** days after your procedure.

Our staff will do their very best to help you with questions and guide you to the proper sources of information. Please contact your insurance company in advance to verify network status, benefits and facility coverage. If you have any questions, please contact us at (970)297-6449, (970)297-6435 or (970)297-6454. Thank you!