

Flexible Sigmoidoscopy

Your procedure is scheduled on: _____ (Date)

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

Pre-Procedure Information:

- ✓ **Harmony Surgery Center is located at:**
2127 East Harmony Road, Suite 200
Fort Collins, CO 80528
Scheduling: (970) 297-6367
If you need directions to our facility, please visit our website at www.harmonyasc.com
- ✓ ****Please go online to www.harmonyasc.com and fill out the Health History and Medication List. From the website, you will click on Patient Registration and then click on the [Health History and Medications List](#). Please fill out this form online and submit it prior to your date of service.**
- ✓ ****If you do not have online access, these forms are included in this packet – please fill them out and bring them with you on your procedure date.**
- ✓ **Please Remember**
If you elect to have sedation for this procedure, 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. 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 970-297-6367. If you cancel with less than a 72-hour notice before your procedure, you may be charged a \$300.00 cancellation fee.

General Information:

- ✓ Included in your packet is the prep instruction sheet specific to the procedure you are having. Please review the instructions.
- ✓ Take your medications as you normally would up until 4 hours before your procedure.

Flexible Sigmoidoscopy Consent Form

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 a FLEXIBLE SIGMOIDOSCOPY which is defined below and may include any of the following:

Flexible Sigmoidoscopy: Examination of the rectum, sigmoid colon, and descending colon up to 65cm with a flexible tube which is passed through the anus.

Biopsy: Removal of small pieces of tissue from within the intestine for analysis.

Polypectomy: Removal of small growths from within the intestine.

Benefits of a Flexible Sigmoidoscopy include but are not limited to the following: The lining of the sigmoid colon and rectum are surveyed for inflammation, tumors, polyps, blockage from post-surgical colon stricture, and bleeding sites.

Alternatives to Flexible Sigmoidoscopy include: Doing no testing, the colon being alternatively viewed by barium enema x-ray and if abnormal one would require a colonoscopy. Polyps may be removed through a surgical procedure, or a colonoscopy.

Risks associated with a Flexible Sigmoidoscopy:

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 Flexible Sigmoidoscopy include:
 - Perforation (making a hole) in the colon or intestine, 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.
3. Any procedure which involves anesthesia/sedation have 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 and prolonged recovery time. Should any complication arise, both the physician directing the administration of these medications and the nurse 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 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.

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.

Flexible Sigmoidoscopy Prep Instructions

In Advance...

- In advance, you will need to purchase **2** Fleet enemas
- Avoid eating: Seeds, Nuts and Corn 5 days before 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.

Prep Instructions....

DAY BEFORE EXAM:

- Please follow a low residue diet: for breakfast and lunch, eat your choice of the following: Canned fruits or vegetables, eggs (except fried), white bread, hot cereals, white chicken, turkey, fish, yogurt, soups, jello (no red or purple), tapioca, fruit and vegetable juices.
- For dinner please have only clear liquids. Clear liquids include anything you can see through. For example: chicken or beef broth, coffee or tea **without cream**, fruit juice, sport drinks or jello. **NOTHING RED OR PURPLE – AND NO SOFT DRINKS PLEASE.**
- **At approximately 7:30 p.m. please use one Fleet enema. You may continue to drink clear liquids the remainder of the evening.**

DAY OF EXAM:

- 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.**
- **Use the second Fleet enema at least 2 hours before leaving for your appointment.**
- Please do not drink or eat anything until after your procedure is complete – no gum, mints, candy or chewing tobacco for 4 hours before your procedure.



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 the 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:**

The anesthesia you receive during your procedure will be supervised by an Anesthesiologist and provided by a Certified Registered Nurse Anesthetist and you will be monitored throughout the procedure. Please call 970-224-2985 if you have questions regarding anesthesia.

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.

Colonoscopy Guidelines to Keep in Mind...

The Affordable Care Act passed in March 2010 allowed for several preventative services, such as colonoscopies, to be covered at no cost to the patient. However, there are many caveats that prevent patients from taking advantage of this provision. There are now strict guidelines that explain which colonoscopies are defined as a preventative service (screening). These guidelines may exclude many patients with gastrointestinal histories from taking advantage of the service at no cost. Patients may be required to pay co-pays and deductibles. In addition, an inadequate bowel prep may result in additional charges.

Diagnostic/therapeutic colonoscopy

Patient has past and/or present gastrointestinal symptoms, polyps, or gastrointestinal disease. This may equate to patient copay, deductible or coinsurance.

Surveillance Colonoscopy

Patient is asymptomatic (no gastrointestinal symptoms), has a personal history of gastrointestinal disease, colon polyps and/or cancer. Patients in this category are required to undergo colonoscopy surveillance at varying ages and intervals based on the patient's personal history. Surveillance colonoscopy is performed to monitor the potential risk of reoccurrence of the condition/disease. This may equate to patient copay, deductible or coinsurance.

High Risk Screening Colonoscopy

Patient is asymptomatic (no gastrointestinal symptoms either past or present), has a family history of gastrointestinal disease, colon polyps, and/or cancer.

Preventive Colonoscopy Screening

Patient is asymptomatic (no gastrointestinal symptoms either past or present), over the age of 50, has no personal or family history of gastrointestinal disease, colon polyps, and/or cancer. The patient has not undergone a colonoscopy within the last 10 years.

Can a diagnosis or procedure code be changed, added, or deleted so that I may be considered a screening procedure?

No. Often insurance representatives will tell a patient that if only the claim was coded with a "screening" diagnosis it would have been covered at 100%. However, the "screening" diagnosis can only be amended if it applies to the patient. Many insurance carriers only consider a patient over the age of 50 with no personal or family history as well as no past or present gastrointestinal symptoms as a "screening" (Z12.11). Furthermore, the patient encounter is documented as a medical record from information you have provided as well as an evaluation and assessment from the physician. It is a binding legal document that cannot be changed to facilitate better insurance coverage. Please understand there are strict government, insurance company and coding guidelines against altering a chart or bill for the sole purpose of coverage determination. This is considered insurance fraud and punishable by law.

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 about this information, please contact us at (970)297-6449, (970)297-6435 or (970)297-6454. Thank you!

HARMONY SURGERY CENTER, LLC

Patient Health History Form

If you do not have online access, please fill out this form and bring it with you on your procedure date

**PATIENT: PLEASE BEGIN HERE AND COMPLETE THE INFORMATION BELOW		
List your allergies to Medicines, Latex (rubber), Food, Tape, Other:		
List your previous surgeries/hospitalizations:		
Prior to your discharge, do you grant our staff permission to go over procedural information, medications and discharge instructions with your ride home? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name and phone number of ride home (note - patient is advised to have a responsible adult with them for 24 hours after procedure):		
Who is your Primary Care Physician:		
Health History:	Yes	No
Height: _____ Weight: _____		
Seizure/stroke or other neurological problem?		
Problems with your heart?		
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®, etc.)?		
Blood disorder?		
Autoimmune disorder?		
Lung problems or problems breathing?		
Do you currently smoke?		
Have you ever smoked? When did you quit?		
Supplemental oxygen?		
Sleep apnea?		
Kidney problems?		
Gastrointestinal or liver problems?		
Diarrhea and/or abdominal cramping? For how long?		
Thyroid, Parathyroid, or adrenal gland problems?		
Cancer treated with chemotherapy or radiation?		
Currently have a contagious or infectious condition?		
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, nervousness, or panic attacks?		
Mental health concerns?		
Used recreational drug(s) within the last 3 days?		
Smoked or consumed marijuana in the past 3 days?		
Drink alcohol? Frequency?		
Dentures or problems with your teeth?		
Eye or vision problems?		

History Continued	Yes	No
Hearing problems?		
Physical restrictions?		
Frequent heartburn?		
Object to blood products under any circumstances?		
Problems with anesthesia (self or blood-relative)?		
Any concerns about anesthesia?		
Is there any possibility you could be pregnant?		
Currently breastfeeding?		
Date of your last menstrual period?		
Do you have an advance directive: <input type="checkbox"/> CPR Directive <input type="checkbox"/> Living Will <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Other		
Do you have someone who can help you at home if needed?		
Do you have any anticipated discharge needs?		
Belongings		
Please list any belongings you have with you upon admission to HSC <input type="checkbox"/> Wallet <input type="checkbox"/> Purse <input type="checkbox"/> Rings <input type="checkbox"/> Glasses <input type="checkbox"/> Other: <input type="checkbox"/> Phone <input type="checkbox"/> Piercings <input type="checkbox"/> Dentures <input type="checkbox"/> Hearing Aid(s) Note: HSC cannot be responsible for belongings. Please give valuables to your ride home.		
Education Assessment		
Do you or your responsible party need information on the following? <input type="checkbox"/> None <input type="checkbox"/> Rehab Techniques <input type="checkbox"/> Medications <input type="checkbox"/> Treatment/Procedures <input type="checkbox"/> Current Illness <input type="checkbox"/> Access to follow-up care <input type="checkbox"/> Diet/Nutrition <input type="checkbox"/> Personal Hygiene/Grooming/Oral Care <input type="checkbox"/> Home Care <input type="checkbox"/> Community Resources <input type="checkbox"/> Equipment <input type="checkbox"/> Other		
Preferred Learning Method:		
<input type="checkbox"/> Listening	<input type="checkbox"/> Demonstrations	<input type="checkbox"/> Videos
<input type="checkbox"/> Reading	<input type="checkbox"/> Hands-On	<input type="checkbox"/> None
Barriers: Check all that apply		
<input type="checkbox"/> None	<input type="checkbox"/> Language	<input type="checkbox"/> Physical
<input type="checkbox"/> Cognitive	<input type="checkbox"/> Culture	<input type="checkbox"/> Financial
<input type="checkbox"/> Hearing	<input type="checkbox"/> Vision	<input type="checkbox"/> Desire/Motivation
<input type="checkbox"/> Read/Write	<input type="checkbox"/> Emotional	<input type="checkbox"/> Religion
<input type="checkbox"/> Other:		
Pain Evaluation		
Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete the following: Pain Level (1-10) _____ Location: _____ Onset/Duration: _____ Description: <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Burning <input type="checkbox"/> Aching Current pain treatment: <input type="checkbox"/> Meds <input type="checkbox"/> Ice <input type="checkbox"/> Elevation <input type="checkbox"/> Heat <input type="checkbox"/> Massage <input type="checkbox"/> Other:		
Signature of patient or person completing form:		
X		

Medication Reconciliation Form

If you do not have online access, please fill out this form and bring it with you on your procedure date

****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 <u>OR</u> refer to prescribing physician:	
					CONTINUE	REFER to MD
1.					<input type="checkbox"/>	<input type="checkbox"/>
2.					<input type="checkbox"/>	<input type="checkbox"/>
3.					<input type="checkbox"/>	<input type="checkbox"/>
4.					<input type="checkbox"/>	<input type="checkbox"/>
5.					<input type="checkbox"/>	<input type="checkbox"/>
6.					<input type="checkbox"/>	<input type="checkbox"/>
7.					<input type="checkbox"/>	<input type="checkbox"/>
8.					<input type="checkbox"/>	<input type="checkbox"/>
9.					<input type="checkbox"/>	<input type="checkbox"/>
10.					<input type="checkbox"/>	<input type="checkbox"/>
11.					<input type="checkbox"/>	<input type="checkbox"/>
12.					<input type="checkbox"/>	<input type="checkbox"/>
13.					<input type="checkbox"/>	<input type="checkbox"/>
14.					<input type="checkbox"/>	<input type="checkbox"/>

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: _____