Harmony SURGERY CENTER

Center for Gastroenterology
Specialists in Digestive Health

Magnesium Citrate

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***
  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:

- ✓ The laxative will cause diarrhea. Good visualization of the colon depends on adequate colon cleaning.

- ✓ If you are unable to complete your prep, notify 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.

Colonoscopy 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 COLONOSCOPY which is defined below and may include any of the following:

Colonoscopy: Examination of the large intestine 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.
Hemorrhoid Ligation: Endoscopic ligation of internal hemorrhoids

Benefits of a colonoscopy include but are not limited to the following: The lining of the colon is surveyed for inflammation, tumors, polyps, blockage from post-surgical colon stricture, and bleeding sites. Pre-cancerous polyps can be removed before they turn into colon cancer.

Alternatives to colonoscopy 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.

Risks associated with a colonoscopy:

1. These are very accurate procedures, but as with any medical test, there is a small chance of missing something (polyps and/or cancer).
2. Possible rare complications associated with Colonoscopy 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 (either immediate or delayed a few weeks) particularly if a biopsy is taken or a polyp is removed.
   - Heart or lung problems, aspiration, pneumonia.
   - Reaction (allergy) to medications.
   - Infection
   - Extremely low risk of injury to the spleen during a colonoscopy.
   - Hemorrhoid ligation: Pain, bleeding, urinary symptoms, edema, tissue ulceration and band dislodgement
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 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.

_____ _____

Name - Patient or Guardian Signature Witness Signature

COLONOSCOPY PREP INSTRUCTIONS – MAGNESIUM CITRATE (page 1 of 2)

To get the best results from your colonoscopy and to avoid having to do the procedure over, please follow these instructions completely unless directed otherwise by your physician. In order for us to examine your colon properly, it must be clean. If you have questions, please call us at 970-297-6303.

Timeline	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 instructions for your blood thinner products as you were directed by your GI physician or cardiologist/prescribing physician. ☐ **IF YOU TAKE INSULIN PRODUCTS OR ORAL DIABETES PILLS:** Contact your physician to obtain specific directions for dosages on the day before and day of your procedure.	For your safety, your procedure will be cancelled if you do not have a ride home arranged.
5 days before procedure	☐ Purchase the following from your pharmacy or drug store: o Three 10-oz bottles of Magnesium Citrate (any flavor, as long as it is CLEAR) o A box of 5 mg Dulcolax® laxative tablets (NOT stool softeners) ☐ Avoid eating: Seeds, Nuts, and Corn 5 days before your procedure.	
1 day before procedure	☐ **BREAKFAST:** You may eat a light breakfast, which may include boiled or poached eggs, white bread, hot cereals, yogurt, chicken, turkey, or fish (not fried) and any clear liquids listed below. ☐ **After breakfast and for the rest of the day**, do not eat anything and drink ONLY clear liquids (Avoid drinking anything that is **RED**, **BLUE**, or **PURPLE**). Clear liquids include: o Water o Chicken or bouillon/beef broth o Coffee or tea without cream o Pulp-free fruit juices (apple, white grape) o Sport drinks like clear Gatorade® o Clear Jello® (no red, blue, or purple) o Clear sodas (Sprite®, 7Up®, ginger ale)	The day before your procedure do not eat any food after breakfast until after your procedure tomorrow.
1 day before at **4 p.m.**	☐ Take **2** Dulcolax laxative tablets (10 mg total) as directed on the package.	
1 day before at **6 p.m.**	☐ Drink 1½ bottles (15 oz) of Magnesium Citrate. ☐ Continue drinking clear fluids throughout the evening.	Remain close to toilet facilities. You may use baby wipes or A&D ointment to alleviate any discomfort from your prep results.

Day of Procedure: **At least 5 hours before procedure time** (For example, if your procedure is at 8 a.m., you will need to get up at 3 a.m. to drink the rest of the Magnesium Citrate.)	☐ 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.** ☐ Drink remaining 1½ bottles (15 oz) of Magnesium Citrate with 16 oz of water or other clear liquid. ☐ After that, **stop all fluids**. ☐ **Do not drink or eat anything starting 4 hours prior to your procedure and until after your procedure is complete, including NO gum, mints, or candy**.	**Please call us at 970-297-6303 if you have not had any bowel movements by the morning of your procedure.** Your bowel movements will turn watery and, toward the end of the prep, will appear yellow or clear. If the bowel movement IS NOT YELLOW OR CLEAR, notify the pre-op nurse when you arrive at the facility.
Appointment time	☐ Please arrive 1 hour before your scheduled procedure time with your responsible adult companion. (see page 1).	For your safety, your procedure will be cancelled if you do not have a ride home arranged.

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? ❑ Yes ❑ 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: ❑ CPR Directive ❑ Living Will ❑ Power of Attorney ❑ 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

❑ Wallet ❑ Purse ❑ Rings ❑ Glasses ❑Other:
❑ Phone ❑ Piercings ❑ Dentures ❑ 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?

❑ None ❑ Rehab Techniques
❑ Medications ❑ Treatment/Procedures
❑ Current Illness ❑ Access to follow-up care
❑ Diet/Nutrition ❑ Personal Hygiene/Grooming/Oral Care
❑ Home Care ❑ Community Resources
❑ Equipment ❑ Other

Preferred Learning Method:

❑ Listening ❑ Demonstrations ❑ Videos
❑ Reading ❑ Hands-On ❑ None

Barriers: Check all that apply

❑ None ❑ Language ❑ Physical
❑ Cognitive ❑ Culture ❑ Financial
❑ Hearing ❑ Vision ❑ Desire/Motivation
❑ Read/Write ❑ Emotional ❑ Religion
❑ Other:

Pain Evaluation

Pain: ❑ Yes ❑ No If yes, please complete the following:
Pain Level (1-10)_____ Location:_____
Onset/Duration:_____
Description: ❑ Dull ❑ Sharp ❑ Burning ❑ Aching
Current pain treatment: ❑ Meds ❑ Ice ❑ Elevation
❑ Heat ❑ Massage ❑ 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 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:_____