

ABOUT YOUR GASTROSCOPY

Dear Patient:

Your physician has referred you for an exam of your upper digestive tract, which is called a gastroscopy. Sometimes it is called an EGD or an upper endoscopy. The purpose of this letter is to familiarize you with the nature of the exam, its benefits and its risks. What follows is absolutely essential for you to know, so please read this carefully. We consider your understanding of this material to be so important that we will ask you to sign this letter acknowledging you have read and understood this information. If you have any questions, please contact us by phone (970-663-2159) before the procedure so we can discuss your concerns with you.

What is an EGD? An EGD is a test done with an endoscope, which is a long, flexible tube that is thinner than most food you swallow. After you are sedated, the tube is passed through the mouth into the upper digestive tract. As a result of the sedation, you are unlikely to gag, feel discomfort, or remember the procedure. The test allows physicians to examine the lining of the esophagus, stomach and duodenum (the first portion of the small intestine).

If the doctor sees a suspicious area, he/she can take a small piece of tissue (a biopsy) for examination in the laboratory. Biopsies are taken for many reasons and do not necessarily imply cancer. The physician can also remove polyps and abnormal tissue during the exam. If a narrowing of the esophagus (also called stricture) is causing difficulty swallowing, the doctor might stretch the narrow spot. This is called an esophageal dilation.

Why is EGD necessary? Many problems of the upper digestive tract cannot be as accurately diagnosed by x-ray. EGD may be helpful in the diagnosis of inflammation of the esophagus, stomach and duodenum (esophagitis, gastritis, duodenitis), hiatal hernia, and to identify the site of upper gastrointestinal bleeding.

EGD is more accurate than x-ray in detecting gastric (stomach) and duodenal ulcers, especially when there is bleeding or scarring from a previous ulcer. EGD may detect early cancers too small to be seen by x-ray and can confirm the diagnosis by biopsies and brushings. Nonetheless, EGD is not 100% accurate in some cases.

Alternatives to EGD. Although endoscopy (EGD) provides a more accurate assessment of the esophagus, stomach and duodenum, certain situations may favor x-ray examination of the stomach. In some circumstances, ultrasound tests, CT scans or even surgery can be considered as alternative studies.

Are there any complications from EGD? EGD is safe and is associated with very low risk when performed by physicians who have been specially trained and are experienced in this endoscopic procedure. Two serious problems that are rarely encountered are perforation (poking a hole) of the intestinal tract and severe bleeding. These events can be life threatening. Treating either of these complications might require surgery and blood transfusions. The risk of either of these events is much less than one percent. Bleeding may occur from the site of biopsy or polyp removal. It is usually



minimal, but rarely may require transfusions or surgery. Localized irritation of the vein (phlebitis) may occur at the site of medication injection. Other risks include drug reactions and complications from unrelated diseases such as heart attack or stroke.

In Summary: EGD is an extremely worthwhile procedure that is very well tolerated and is invaluable in the diagnosis and proper management of disorders of the upper digestive tract. The decision to perform this procedure is based upon assessment of your particular problem. If you have any questions about your need for an EGD, do not hesitate to speak to the doctor. Both of you share a common goal—your good health – and it can only be achieved through mutual trust, respect and understanding.

Please contact us at 970-663-2159 if you would like to discuss any of this further. You will, of course, have an opportunity to speak to us immediately before the procedure.

Sincerely Yours,



Stephen R. Sears, MD



Lewis R. Strong, MD



Daniel A. Langer, MD



Crystal M. North, DO



Sean P. Caufield, MD

By signing here, you certify that you have read and understood the information pertaining to the EGD (Upper Endoscopy). If you have questions, please do not sign this until we have answered them for you.

Name _____ Date _____



GASTROSCOPY PREP

Your physician has scheduled you for a gastroscopy. Please follow the instructions below.

- ✓ If you need to cancel or reschedule your procedure for any reason, please call the Endoscopy Scheduler at 970-663-2159 at least 48 hours prior to your exam.
- ✓ For questions after hours call 970-669-5432 and ask for the gastroenterologist on-call.
- ✓ **Completely fill out the “TELL US ABOUT YOURSELF” form in your packet. Bring the completed form and your packet with you the day of your procedure.**

General Information:

- ✓ **If any of the following conditions apply to you, you must be seen in the endoscopist’s office prior to your procedure. Do you:**
 - Take a blood-thinning medication?
 - Have congestive heart failure?
 - Use oxygen at home?
 - Have any implanted electronic devices?
- ✓ Make arrangements to have a responsible adult drive you home. Public transportation is not allowed unless you have an adult to accompany you. Your driver should plan to stay at the facility during your procedure.
- ✓ After the procedure, you should have an adult with you for 4 to 6 hours.
- ✓ Take your prescribed medications as you normally would up until 2 hours before your procedure.

INSTRUCTIONS FOR THE PROCEDURE:

- ✓ _____ **You should STOP ALL SOLID FOOD for 8 hours before your procedure.**
You may continue drinking clear liquids.
- ✓ _____ **You should STOP ALL LIQUIDS for 2 hours before your procedure.**
(Take nothing by mouth for these 2 hours)

DIABETIC INSTRUCTIONS:

- ✓ If you are a diabetic and your procedure is scheduled to be done in the morning, hold your medications or insulin the morning of the procedure. Plan on eating and taking your medication about one hour after your procedure. We suggest you check your blood sugar at least 4 times a day at mealtime and bedtime.
- ✓ If you are diabetic and your procedure is scheduled to be done in the afternoon, contact your primary care physician to confirm how to take your diabetic medications. We suggest you check your blood sugar at least 4 times a day at mealtimes and bedtime.



GASTROSCOPY CONSENT FORM

CONSENT FOR PROCEDURE



Patient: _____

1. PROCEDURE AND ALTERNATIVES: I, (patient or authorized representative) authorize Dr. _____ to perform procedure: **Esophagogastroduodenscopy (EGD with possible biopsy, esophageal or gastric outlet dilation).**

I understand the reason for the procedure is: **Examination of the esophagus, stomach and duodenum with possible removal of tissue for diagnosis. There may also be possible dilation of a stricture of the esophagus or gastric outlet.**

Alternatives include: x-rays, do nothing, or _____

2. RISKS: This authorization is given with the understanding that any procedure involves some risks and hazards. The more common risks include: infection, bleeding, nerve injury, blood clots, heart attack, allergic reactions, aspiration pneumonia and missed lesions. These risks can be serious and possibly fatal. Some significant and substantial risks of this particular procedure include: **BLEEDING OR PERFORATION. IF EITHER OF THESE COMPLICATIONS OCCUR, TREATMENT MAY INCLUDE HOSPITALIZATION, SURGERY OR BLOOD TRANSFUSION.**

3. SEDATION AND ANESTHESIA: The administration of sedation and anesthesia also involves risks, most importantly a rare risk of reaction to medications causing death. I consent to the use of such sedatives or anesthetics as may be considered necessary by the person responsible for these services.

4. RESUSCITATION: I desire all resuscitative measures be employed during the procedure.

5. ADDITIONAL PROCEDURES: If my physician discovers a different, unsuspected condition at the time of the procedure, I authorize the physician to perform such treatment as deemed necessary to improve health.

6. I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure the condition.

7. I consent to the photographing of the procedure to be performed for medical purposes.

8. I consent to the admittance of medical or paramedical observers to the procedure room.

9. I hereby request and authorize this health care facility to preserve for scientific or teaching purposes or otherwise dispose of the removed tissue resulting from the procedures authorized above. I further authorize the pathologist, whose services may be required, to use discretion in the disposal.

NOTE: IF YOU HAVE ANY QUESTIONS ABOUT THE PROCEDURE, OR THE RISKS OR CONSEQUENCES ASSOCIATED WITH IT, TALK WITH YOUR PHYSICIAN. YOU MAY WITHDRAW THE CONSENT FOR THIS PROCEDURE AT ANY TIME PRIOR TO ITS PERFORMANCE. DO NOT SIGN THIS CONSENT UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.

Patient/Authorized Representative

Date and Time

Relationship of Authorized Representative

PHYSICIAN DECLARATION: I have discussed the procedure, risks, complications, consequences, and alternatives with the patient or patient's representative, and to the best of my knowledge, the patient or representative understands this information and consents to the proposed procedure.

Physician's Signature



TELL US ABOUT YOURSELF

Please complete this form and bring it and this packet to your procedure.

Why are you having this procedure? _____

Do you take Warfarin (Coumadin)? Yes No *Do you use oxygen at home?* Yes No

Are you, or could you be, pregnant? Yes No

Do you smoke or use tobacco products? Amount _____ *Do you drink alcohol? Amount* _____

Do you use marijuana products? Yes No

Do you have any of the following medical conditions. If yes, please briefly explain.

- Yes No Diabetes _____
- Yes No High Blood Pressure _____
- Yes No Heart Disease _____
- Yes No Asthma/COPD _____
- Yes No Stroke _____
- Yes No Liver Problems _____
- Yes No Blood Clots _____
- Yes No Kidney Problems _____
- Yes No Sleep Apnea _____
- Yes No Other _____

Previous Surgeries:

Surgery/Approximate Date:

Surgery/Approximate Date:

Please list any of your blood relatives with a history of colon cancer or colon polyps:

Previous Endoscopic Procedures:

Colonoscopy _____

Approximate Date: _____

Upper Endoscopy _____

Approximate Date: _____

Do you have a living will? Yes No *Do you have medical durable power of attorney?* Yes No

Do you want any information regarding these? Yes No

Signature _____

Date _____

Health History has been reviewed by _____ *RN Date* _____ *Time* _____

Please complete medication form on back page.



MEDICATION FORM

Name: _____ Date: _____

ALLERGIES: _____

At Skyline Endoscopy Center we understand that the safe management of your medications may be a challenge and we can provide assistance. In fact, it is something we take very seriously. We join with your physician in developing systems that assure that your next provider of care has full knowledge of your current medications. This allows safe administration of new drugs and avoiding duplication of drugs or dangerous drug interactions.

We call this "Reconciliation"...We think this is Important...and so should you!

You can help us by completing this form before you come to the Center. After your procedure is completed a copy of this form will be handed back to you with additional medications you received during your stay at the Center or that were prescribed for you on discharge.

PLEASE PRINT CLEARLY ANY MEDICATIONS YOU ARE TAKING—INCLUDING PRESCRIPTIONS, OVER THE COUNTER MEDICATIONS AND HERBALS

DRUG NAME	STRENGTH	HOW MANY TIMES A DAY	TAKE FOR WHAT PURPOSE

NEW INSTRUCTIONS/PRESCRIPTION(S) ADDED TODAY UPON DISCHARGE:

DURING YOUR VISIT YOU WERE GIVEN:

- PROPOFOL FOR SEDATION
- VERSED FOR SEDATION
- FENTANYL FOR DISCOMFORT
- CETACAINE SPRAY
- OTHER MEDICATIONS:

REVIEWED BY: _____

DATE: _____

WHAT TO EXPECT AFTER YOUR GASTROSCOPY

Dear Patient:

Please follow these guidelines to ensure the best possible outcome after your procedure:

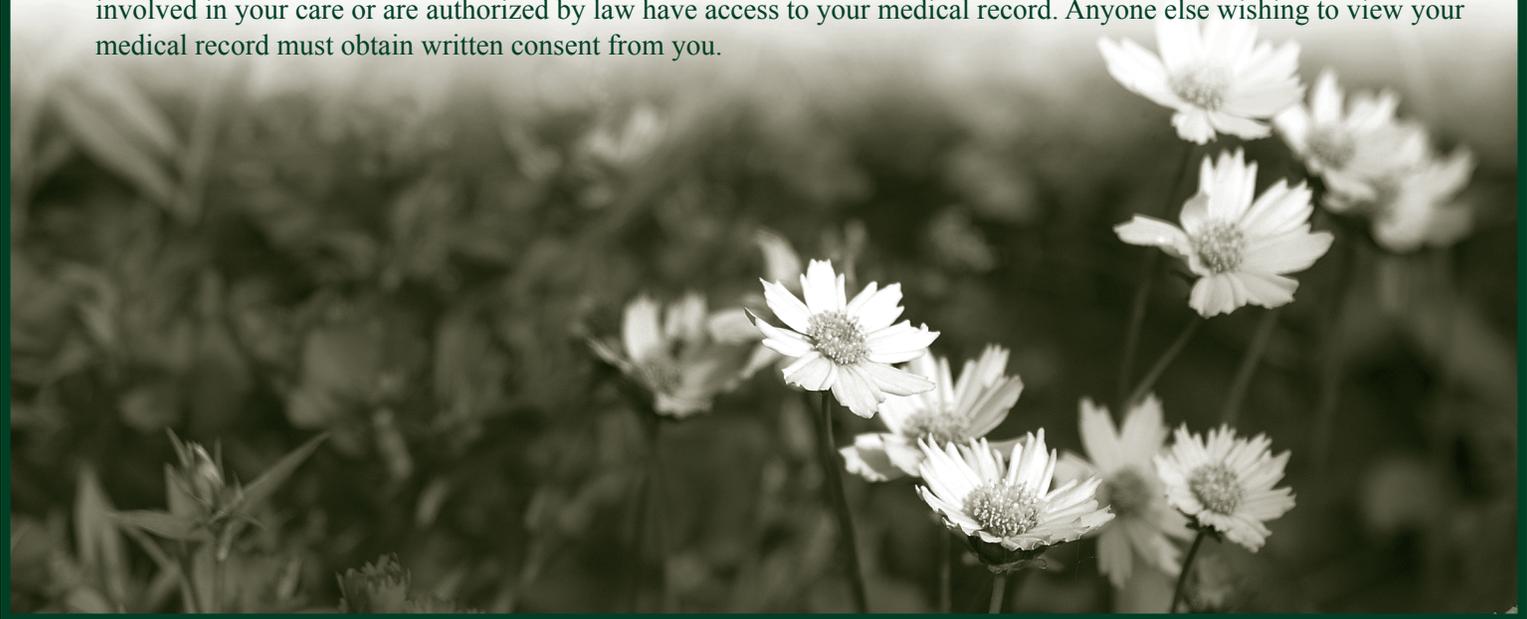
- ✓ Do not drive, operate hazardous machinery, or make critical legal decisions for at least 12 hours.
- ✓ You should be in the presence of an adult for 4-6 hours after your procedure.
- ✓ Resume medications when you start eating unless otherwise instructed.
- ✓ Mild bloating is normal. Discomfort can be relieved by walking.
- ✓ You may have a slightly sore throat which could last 1-2 days. Use warm salt-water gargles or lozenges.
- ✓ If biopsies are taken you will be contacted with results within 1-2 weeks.
- ✓ You should call us at 970-669-5432 immediately, and at any time of day or night, if you have a fever, severe throat or neck pain, or persistent abdominal, back or chest pains, shortness of breath, or any concerns.



NOTICE OF PATIENT RIGHTS & RESPONSIBILITIES

When you are a patient at Skyline Endoscopy Center, you have the following rights:

1. You have the right to receive quality care and treatment in a safe setting that is considerate and respectful of your dignity and personal values.
2. You have the right to participate in all decisions involving your health care and to understand what is expected of you.
3. You have the right to be interviewed, examined and treated in surroundings that provide reasonable privacy.
4. You have the right to be free from all forms of abuse or harassment.
5. You have the right to know the names, professional status and experience of the staff providing your care and treatment.
6. You have the right to know if the Endoscopy Center is participating in teaching programs, research and/or experimental programs. You can refuse to participate in any such program.
7. You have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of your decisions.
8. You have the right to be informed of the Endoscopy Center's rules and regulations that apply to your conduct while a patient here.
9. You have the right to give informed consent for all treatments and procedures. Informed consent includes:
 - a. An explanation of the recommended treatment or procedure in layman's terms.
 - b. An explanation of the risks and benefits of any treatment or procedure, the probability of success, and any potential complications.
 - c. An explanation of the alternatives with the risks and benefits of these alternatives.
 - d. An explanation of the consequences if no treatment is pursued.
 - e. An explanation of the recuperative period, which includes the expected length of that period.
10. You have the right to receive an estimate of the charges for service based on your admitting diagnosis. Based on the insurance information you provide, you have the right to receive an estimate of any copayment or other charges that will not be covered by a third party payer (insurance company).
11. You have the right to see your medical record within the guidelines established by law. Only those individuals who are involved in your care or are authorized by law have access to your medical record. Anyone else wishing to view your medical record must obtain written consent from you.



12. You have the right to make advance directives. There are two types of advance directives permitted by Colorado law. The Colorado Medical Durable Power of Attorney for Healthcare lets you name someone to make decisions about your medical care including decisions about life support if you can no longer speak for yourself. The Colorado Declaration as to Medical or Surgical Treatment is the state's living will form. It lets you state your wishes about medical care in the event that you develop a terminal condition and are either unconscious or otherwise incompetent to make your own medical decisions. For more information on Colorado advance directives and to obtain advance directive forms, go to www.caringinfo.org/files/public/ad/Colorado.pdf.
13. You have the right to know that it is Skyline Endoscopy Center's policy, regardless of the contents of any advance directive or instructions from a health care surrogate or attorney in fact, that if an adverse event occurs during your treatment at this facility we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation.
14. You have the right to express your complaints and concerns about care received without fear of recrimination. You may contact the Nurse Manager or Administrator at 970-663-2159. In addition, you may report a complaint to the Colorado Department of Public Health and Environment at 303-692-2800 or 1-800-886-7689, ext. 2800. You may also contact the Medicare Hotline at 1-800-633-4227 or <http://medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html>. Or, you may contact the Colorado Department of Regulatory Agencies at www.dora.state.co.us/medical/complaints.htm.
15. You have the right to exercise your rights without being subjected to discrimination or reprisal.

When you are a patient at Skyline Endoscopy Center, you have the following responsibilities:

1. Provide accurate and complete information about present problems, past illnesses, hospitalizations, medications, and other matters relating to your health.
2. Provide accurate and updated information for insurance and billing.
3. Cooperate with all Endoscopy Center personnel and ask questions if you do not understand directions or procedures.
4. Act in a respectful and considerate manner toward healthcare providers, other patients, and visitors. Verbal or physical harassment is not tolerated.
5. Assist in keeping noise and the number of visitors to a minimum.
6. Be respectful of the property of other persons and the facility.
7. Indicate if you feel your privacy is being violated.
8. Indicate if you feel your safety is being threatened.

Disclosure: Drs. Langer, North, Sears and Strong have a financial interest in Skyline Endoscopy Center.

