

ABOUT YOUR UPPER ENDOSCOPY

Dear Patient:

Your physician has referred you for an exam of your upper digestive tract, which is called an upper endoscopy or an EGD. Sometimes it is called a gastroscopy. 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 understand 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.

The actual examination usually takes about 15 minutes. After the procedure, it will take you about half an hour to wake up enough to go home. Most people are in and out of the endoscopy center in about two hours.

Why is an EGD necessary? Many problems of the upper digestive tract cannot be as accurately diagnosed by x-ray. An 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.

An 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. An EGD may detect early cancers too small to be seen by x-ray and can confirm the diagnosis by biopsies and brushings. Nonetheless, an EGD is not 100% accurate in some cases.

Alternatives to an EGD. Although an upper 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 an EGD? An 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: An 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 _____



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.

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma/COPD _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Problems _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blood Clots _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Problems _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sleep Apnea _____
<input type="checkbox"/> Yes	<input type="checkbox"/> 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 a 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: _____

UPPER ENDOSCOPY PREP

Your physician has scheduled you for an Upper Endoscopy (EGD). 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” and “MEDICATION” forms in your packet. Bring the completed forms and your packet with you the day of your procedure.**

General Information:

- ❑ 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 3 hours before your procedure.

INSTRUCTIONS FOR THE PROCEDURE:

- ❑ You should **STOP ALL SOLID FOOD for 8 hours before your procedure and take ONLY clear liquids.** On your clear liquid diet you may have only: water, coffee, tea, soda, broth, bouillon, liquid or set jello, popsicles, juices without pulp such as apple, cranberry, or grape juice. No juice with pulp is allowed. NO milk or cream products are allowed.
- ❑ You should **STOP TAKING ANYTHING BY MOUTH for 3 hours before your procedure.** (This includes NO hard candy, chewing gum or water.)

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. 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.

WHAT TO EXPECT AFTER YOUR UPPER ENDOSCOPY

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.



UPPER ENDOSCOPY CONSENT FORM

CONSENT FOR PROCEDURE



Patient: _____

1. PROCEDURE AND ALTERNATIVES: I, (patient or authorized representative) authorize Dr. _____ to perform procedure: **Esophagogastroduodenscopy (Upper Endoscopy, 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



NOTICE OF PATIENT RIGHTS & RESPONSIBILITIES

PATIENT RIGHTS

Decision Making

You or your representative have the right to:

- Be informed before care is given or discontinued whenever possible.
- Receive accurate and current information regarding your health status in terms you can understand.
- Participate in planning for your treatment, care and discharge recommendations.
- Receive an explanation of proposed procedures or treatments, including risks, serious side effects and treatment alternatives, including request for second opinion.
- Participate in managing your pain effectively.
- Receive emergency care or transfer to a higher level of care (hospital), if necessary, with a full explanation of your medical need for transfer. No wait for insurance authorization will be required and no financial penalty will be imposed.
- Have persons of your choice promptly notified of hospital admission.
- Accept, refuse or discontinue a treatment or drug, to the extent permitted by law, and be informed of the consequences of such refusal.
- Accept, refuse or withdraw from clinical research.
- Accept, refuse or withdraw from diagnostic or therapeutic procedures.
- Choose or change your healthcare provider.

Equality of Care

You have the right to:

- Respectful treatment, which recognizes and maintains your dignity and personal values without discrimination on the basis of race, color, national origin, sex, age or disability.
- Accurate information about the facility where services are received and the name, credentials and job function of health care personnel involved in your care.
- Interpreters and/or special equipment to assist with language needs.
- Information on how to obtain auxiliary aids or services should these be required.
- Information about continuing healthcare requirements following discharge, including how to access care after hours.

Confidentiality and Privacy

You have the right to:

- Personal privacy and care in a safe setting free from abuse, harassment, discrimination or reprisal.
- Sharing of personal information only among those who are involved in your care.
- Confidentiality of your medical and billing records.
- Notification of privacy practices.
- Notification of breach of unsecured personal health information.

Grievance Process

You, or your representative, have the right to:

- Fair and objective review of any complaint you have regarding care received from healthcare providers/personnel, without fear of reprisal.
- Submit a formal complaint either verbally or in writing as shown below. You will receive a written notice of decision within 15 business days from the date the complaint was made known to the Center.

Administrator of ASC serving as Compliance Officer: 970-541-2582

Colorado Department of Health: 303-692-2904 or email: hfdintake@cdphe.state.co.us

Department of Registry Agency: 303-894-7800 or <http://www.dora.state.co.us/medical/complaints.html>

CMS Ombudsman: 1-800-MEDICARE (1-800-633-4227) or
<http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html>

Office of Inspector General: 800-447-8477 or <https://www.oig.hhs.gov/hotlineoperations>, or US Department of Health & Human Services, Attn: OIG Hotline Operations, P.O.BOX 23489, Washington D.C. 20026

Office of Civil Rights: <https://www2.ed.gov/about/offices/list/ocr/docs/howto.html>

Advance Directives

You have the right to know that:

- You may provide a Living Will and/or Medical Power of Attorney.
- It is Skyline Endoscopy Center's policy, regardless of the contents of any advance directive or instructions from a healthcare surrogate, that if a life threatening condition should occur during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you via ambulance to an acute care hospital for further evaluation.

Access to Medical Records

You have the right to:

- Speak privately with health care providers knowing that your health care information is secure.
- Review and/or receive a copy of your Medical Records (including electronic format), within 30 days by secure transmission, upon written request.

Seclusion and Restraints

You have the right to:

- Be free from seclusion or restraint for behavioral management unless medically necessary to protect your physical safety or the safety of others.

Billing

You have the right to:

- Information specific to fees for services and payment policies, prior to the date of service.
- Payment privacy when you choose to opt out of insurance coverage, in accordance with federal regulations.

PATIENT RESPONSIBILITIES

Providing Information

You have the responsibility to:

- Provide accurate and complete information about present problems, past illnesses, hospitalizations, current use of prescribed or OTC medications, current use of nutritional supplemental products, and other health-related matters.
- Report perceived risks in your care and unexpected changes in your condition.
- Provide an Advance Directive, if you have one.
- Provide accurate and updated demographic and contact information for insurance and billing.

Involvement

You have the responsibility to:

- Participate in your plan of care and follow the recommended treatment plan.
- Ensure you have a designated responsible adult to provide transportation and assist with your care for 4-6 hours after your procedure.

Respect and Consideration

You have the responsibility to:

- Act in a respectful and considerate manner toward healthcare providers, other patients, and visitors; physical or verbal threats or conduct, which are disruptive to business operations, will not be tolerated.
- Be respectful of the possessions or property of others, as well as the facility property.
- Assist in keeping noise levels and the number of visitors to a minimum.

Insurance Billing

You have the responsibility to:

- Know the extent of your insurance coverage.
- Know your insurance requirements including pre-authorization, deductibles and co-payments. Deductible amounts owed and copayments are expected at time of service.
- Call the billing office with questions or concerns regarding your bill.
- Fulfill your financial obligations as promptly as possible.

Drs. Langer, North, Sears, Strong and Caufield have a financial ownership in Skyline Endoscopy Center.