

ABOUT YOUR COLONOSCOPY

Dear Patient:

Your physician has referred you for a colonoscopy. 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.

Why you should have a colonoscopy: Colonoscopy is an examination of the entire colon (large intestine) using a long, thin, flexible tube with a television camera on the tip called a colonoscope. The procedure is done for a number of different purposes. The most common goal is an effort to prevent colon cancer. Without any screening, about one out of twenty people will develop colon cancer. The risk is even higher for people with a family history of colon cancer. Most, but not all, cancers begin as benign tumors called colon polyps. Over time polyps can grow and become cancers. Finding and removing colon polyps markedly reduces your risk of developing colon cancer. Likewise, if a colonoscopy is done, and no colon polyps are found, it is unlikely that you will have problems with colon cancer within the next 5 years. Other reasons for having a colonoscopy include searching for a cause for diarrhea, abdominal pain, blood in the stools, and anemia.

The procedure: The preparation for the examination starts with a laxative, which is described in detail in the prep instructions. Good visualization of the colon depends on an adequate colon cleansing.

The actual examination usually takes between 15 and 30 minutes. Before the procedure an IV will be started in order to give necessary medications. Heart and lung function monitors are used to enhance safety. You will lie in a comfortable position in a bed. To prevent cramping and pain during the procedure you are sedated. The setting is calm and private. Because of the medications, you will probably remember little or none of the procedure. It is unlikely that you will find the examination to be unpleasant. Most people feel that the only unpleasant part of the entire process is the laxative, but as noted above, it is vital to the success of the procedure.

After the procedure, it will take you about a half an hour to wake up enough to leave the endoscopy center. Most people are in and out of the endoscopy center in about two hours. Because of the sedation, you will need a ride home. You will not be able to drive for at least 12 hours. You will probably be able to resume most of your normal activities about six hours after the procedure. If polyps are removed, there is a small risk of bleeding for up to two weeks afterwards. For this reason, you should only have the procedure done if you will be within easy reach of an emergency room for the next 14 days.



Examples of activities you need to avoid for two weeks after polyps are removed include travel in airplanes and backcountry recreation. It is fine to drive to areas with reasonable levels of emergency medical care.

The Limitations of Colonoscopy: Colonoscopy is the most effective cancer preventative test we have, but it is not perfect. Having a colonoscopy can be expected to decrease your risk of dying from colon cancer by about 90 percent over the next five to ten years. Unfortunately, cancers can still develop, although very rarely, in this interval after a colonoscopy. This occurs for two main reasons. First of all, polyps can be missed during a colonoscopy. In the best of circumstances, this seems to happen to about 10 percent of polyps. This problem is due to difficulty in seeing the entire colon because of the presence of sharp folds and corners, poor cleansing of the colon, and limitations in the view of the TV camera. These factors can all create “blind spots”. The second cause for the appearance of cancers within several years of a colonoscopy is that some cancers simply seem to develop extremely rapidly. While not perfect, colonoscopy is still extremely worthwhile since it can be expected to prevent the vast majority of deaths that would otherwise occur from colon cancer. At this time, colonoscopy is the most effective screening tool for colon cancer.

Alternatives to Colonoscopy: Other screening tests for colon cancer include testing the stool for occult (invisible) blood, a limited scope exam without sedation called a flexible sigmoidoscopy, and barium enema X-ray. All of these have been shown to prevent some cases of colon cancer, but they are far less reliable than a colonoscopy. Furthermore, if they do detect a problem, in all cases you will need a colonoscopy to confirm the result. While they are better than doing nothing, these three alternative screening methods are clearly inferior to colonoscopy for protecting your health. CT and MRI scanning colon exams are available, but are still in development. At this time they are of uncertain benefit. In addition, these procedures may require the same prep and are often not covered by insurance. Furthermore, if polyps are found, a follow-up colonoscopy will be required to remove them.

The Risks of Colonoscopy: Like all invasive medical procedures, colonoscopy has a chance of causing complications. Fortunately, the odds of a complication are very low. Two serious problems that are rarely encountered are perforation (poking a hole) of the colon 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. They occur somewhere between 1 in 500 to 1 in 1000 colonoscopies. Less common problems are severe medication reactions or heart attacks. Localized irritation of the vein (phlebitis) may occur at the site of medication injection. While these complications do rarely occur, it must be remembered that the risk of dying from colon cancer is far higher than the risk of suffering a complication from the examination. Your safety is our foremost concern, and the entire process is designed to minimize your chances of injury.

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 contents of this letter. 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

Please complete 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 a notation of any medications you received during your stay at the Center or that were prescribed for you on discharge.

Allergies or Intolerances to Medications or Substances and Reaction: ☐ No Known Drug Allergies

Home Medication on Admission (Prescriptions, OTC, Vitamins, Supplements, Patches, Inhalers, etc.)				
Medication and Route (if other than by mouth)	Reason for taking medication	Dose	Frequency	Last Taken

Verified medication list with patient pre-procedure: (RN initials)

Medications given on date of procedure:

Pre-procedure:

☐ No medications

☐ Medications given:

During procedure:

☐ No medications

☐ Propofol for sedation

☐ Fentanyl for sedation

☐ Other medications:

After procedure:

☐ No medications

☐ Medications given:

New Medications/Previous Medications with Changes				
Medication	Dose	Frequency	Last Taken	Indications/Instructions

Above is a list of medications that you indicated you are currently taking. Unless otherwise noted, you should resume taking these medications. Please contact the physician who prescribed you medications if you have any questions. Medication prescribed as a result of your visit has been noted as well. Your signature below means you understand these instructions.

Patient/Responsible Party signature:

Reviewed and copy sent with patient/responsible party:

Date: RN Initials:

COLYTE COLONOSCOPY PREP

Your physician has scheduled you for a colonoscopy. 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.
- ☐ If you are unable to complete your prep, notify the Skyline Endoscopy Center at 970-663-2159. 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 exam.**

General Information:

- ✓ **If any of the following conditions apply to you, you must be seen in the endoscopist's office or obtain the endoscopist's authorization prior to your procedure. Do you:**
 - ☐ Take a blood-thinning medication?
 - ☐ Have congestive heart failure?
 - ☐ Use oxygen at home?
 - ☐ Have any implanted electronic devices?
- ✓ For 5 days prior to your procedure, try to avoid nuts, seeds and corn.
- ✓ Take your prescribed medications as you normally would up until 3 hours before your procedure.
- ✓ This laxative will cause diarrhea. Please follow the instructions on the back of this page.
Good visualization of the colon depends on adequate colon cleansing.
- ✓ Make arrangements to have a responsible adult drive you home. Your driver should plan to stay at the facility during your procedure. Public transportation (bus, taxi, shuttle) is NOT allowed unless you have a responsible adult with you.
- ✓ After the procedure, you should have an adult with you for 4 to 6 hours.
- ✓ If polyps are removed, plan to remain in this area or an area easily accessible to emergency health care for 14 days after the procedure.

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.

(see other side for prep instructions)



In advance, you will need to purchase **a bottle of Colyte (Golytely, Nulytely, or other equivalent brand) by prescription** from the pharmacy of your choice. **Colyte prescription is included in your packet.**

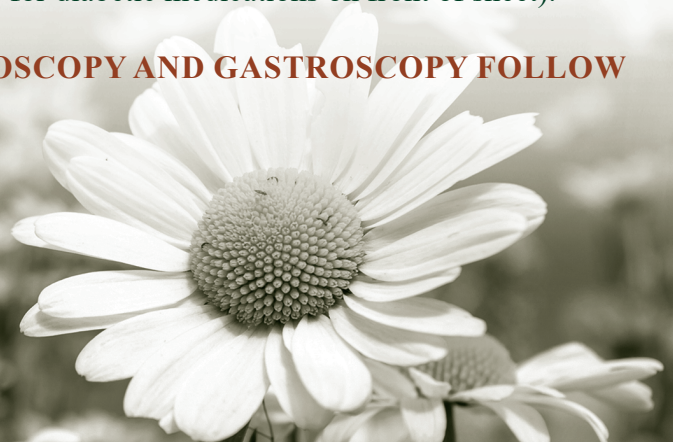
PLEASE NOTE: If you previously have not been able to use the Colyte type prep (laxative mixed with one gallon of water), call 669-5432 at least 24 hours before starting prep to get alternate instructions.

DRINK PLENTY OF CLEAR LIQUIDS TO PREVENT DEHYDRATION.

Suggestion: Sucking on lemon drops while you are taking the laxative may make it more tolerable.

- ☐ **The day before your exam for breakfast** you may have only white bread/toast, rice cereal, cream of wheat, eggs, milk, and/or juice. NO fruit, vegetables, nuts or seeds.
- ☐ **After breakfast switch to clear liquids.**
- ☐ **On your clear liquid diet you may have only:** water, coffee, tea, soda, broth, bouillon, liquid or set jello, popsicles (no red jello or popsicles), juices without pulp such as apple, cranberry or grape juice. No juice with pulp is allowed. No milk or cream products are allowed.
- ☐ At 5 p.m. mix the Colyte contents (or the brand provided by your pharmacist) with 1 gallon (4 liters) of water in the container provided. Shake or mix well. You may chill the solution but do not ice it. To improve the taste you can add Crystal Light (not red colored) to the Colyte.
- ☐ Studies show that split dosing does a better job of cleaning the colon. You will take part of the laxative the night before and the remainder of the laxative the next morning before your procedure.
- ☐ At 6 p.m. begin drinking the Colyte solution. Drink 8 ounces (1 cup) every 10-15 minutes until you have drunk 13 cups. This is $\frac{3}{4}$ of the gallon container. Save 4 cups (or $\frac{1}{4}$ of the container) for the next morning. You should be having clear, light yellowish, watery diarrhea. You can continue drinking clear liquids the night before your procedure.
- ☐ 4 hours before you are scheduled to arrive for your procedure, drink 8 ounces (1 cup) every 10-15 minutes until you have finished the remainder of the gallon container. You should be finished drinking the Colyte solution within one hour. **Drink all of the prep even if you are having clear watery diarrhea.** (Your stools may initially be dark liquid when you get up in the morning. This is normal.)
- ☐ 3 hours before you are scheduled to arrive, do not eat or drink anything. (No hard candy or gum.)
- ☐ Take prescribed medications as you normally would up to 3 hours before your procedure, except for diabetic medications (see instructions for diabetic medications on front of sheet).

IF YOU ARE SCHEDULED FOR BOTH A COLONOSCOPY AND GASTROSCOPY FOLLOW THE SAME INSTRUCTIONS AS LISTED ABOVE.



WHAT TO EXPECT AFTER YOUR COLONOSCOPY

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 or lying on your stomach.
- ❑ If a polyp is removed, you must remain in this area or an area easily accessible to emergency health care for 14 days.
- ❑ If biopsies are taken you will be contacted with results within 1-2 weeks.
- ❑ You may have a small amount of blood on the toilet paper or in the stool after bowel movements. If you pass large amounts of blood or blood clots, call us at 970-669-5432 immediately, and at any time of day or night, or go to the nearest emergency department.
- ❑ You should call us at 970-669-5432 immediately, and at any time of day or night, if you have a fever or persistent abdominal, back or chest pains, shortness of breath, or any concerns.



COLONOSCOPY CONSENT FORM

CONSENT FOR PROCEDURE



Patient: _____

1. PROCEDURE AND ALTERNATIVES: I, (patient or authorized representative) authorize Dr. _____ to perform procedure: **Colonoscopy with possible biopsy and/or polypectomy.**

I understand the reason and **BENEFITS** for the procedure are: **Examination of the colon with possible removal of tissue and/or removal of a polyp for diagnosis.**

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 including polyps or cancer. 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 sedation 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.