ABOUT YOUR SIGMOIDOSCOPY

Dear Patient:

Your physician has referred you for a sigmoidoscopy. 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 sigmoidoscopy: A sigmoidoscopy is an examination of the lower portion of the colon (large intestine) using a long, thin, flexible tube with a camera on the tip called a colonoscope. The procedure is done for a number of different purposes, such as evaluation of colitis, diarrhea, rectal bleeding, or for follow-up of a polyp.

The procedure: The actual examination usually takes between 10 and 15 minutes. You will lie in a comfortable position in a bed. The setting is calm and private.

If you do not receive sedation, you may experience some mild lower abdominal cramping. You can be discharged immediately after your procedure and can drive yourself home.

If your doctor has recommended sedation, an IV will be started prior to your procedure in order to give the necessary medications. Heart and lung function monitors are used to enhance safety. 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. After the procedure, it will take you about 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.

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.

❑ 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 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: _____

SIGMOIDOSCOPY PREP

Your physician has scheduled you for a sigmoidoscopy. 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 FORM" in your packet. Bring the completed forms and your packet with you the day of your exam.**

General Information:

- ✓ 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.
- ✓ If you do not receive sedation, you will be able to drive yourself home.

If you receive sedation:

- ✓ 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.

In advance, you will need to purchase 2 fleets enemas from your pharmacy.

- ❑ Consume only clear liquids after midnight and the day of your test. If you are receiving sedation, do not drink anything for 3 hours before your exam.
- ❑ Use both Fleets Enemas 1 1/2 hours prior to the exam, 10-15 minutes apart.

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 SIGMOIDOSCOPY

Dear Patient:

Please follow these guidelines to ensure the best possible outcome 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.

If you receive sedation:

- 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.

SIGMOIDOSCOPY CONSENT FORM

CONSENT FOR PROCEDURE

SKYLINE ENDOSCOPY CENTER

Patient: _____

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

I understand the reason and **BENEFITS** for the procedure are: **Examination of the lower 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**

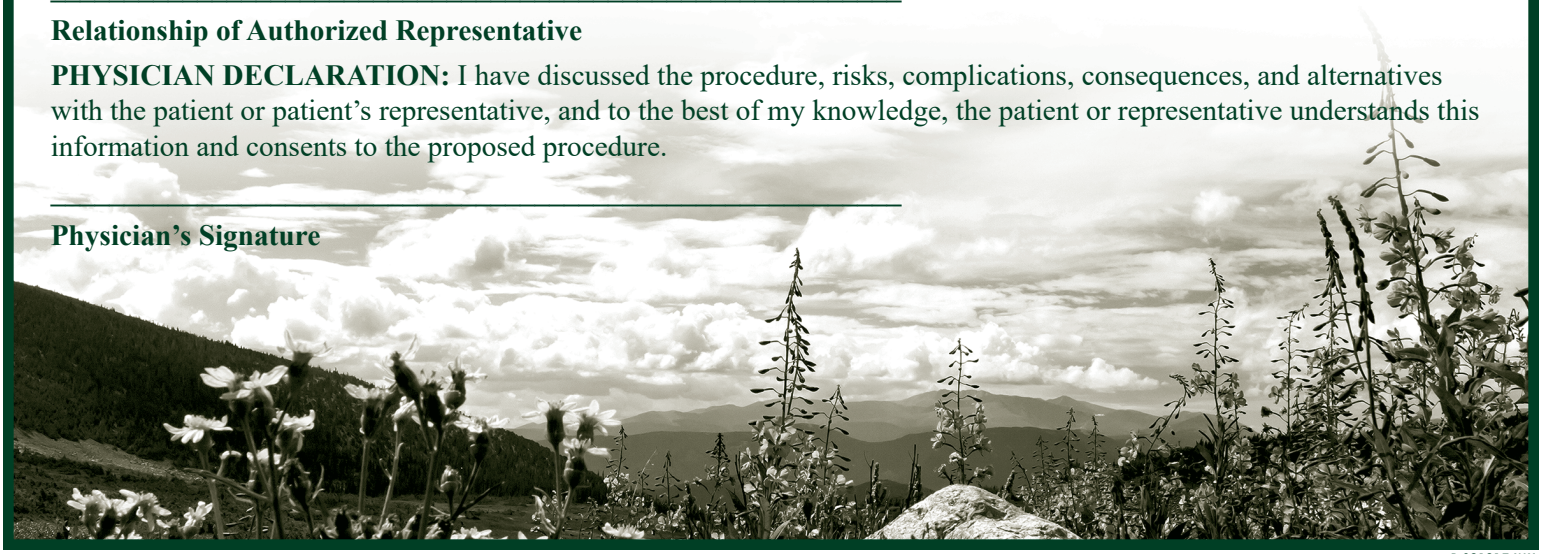
_____

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