Digestive Health Specialists, P.A.
Colon Cancer Prevention Center
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Upper GI Endoscopy Information and Instructions

Your procedure is scheduled on _____ and will be performed at the following location:

___ DHS Endoscopy Center, 2025 Frontis Plaza, Suite 210, Winston Salem, NC 27103
___ DHS Office Endoscopy, 137 Mt. Calvary Road, Suite A Thomasville, NC 27360
___ DHS Office Endoscopy, 280 Broad Street, Suite G, Kernersville, NC 27284
___ DHS Office Endoscopy, 112 East Kinderton Way, Suite 100, Advance, NC 27006
___ Forsyth Medical Center, Endoscopy Center, 3333 Silas Creek Pkwy, Winston Salem 27103
___ Thomasville Medical Center, 207 Old Lexington Road, Thomasville, NC 27360
___ J.R. Jones Medical Center, (Pioneer Medical Ctr.) 402 West King St., King, NC 27021
___ Kernersville Medical Center, 1750 Kernersville Medical Parkway, Kernersville, NC 27284

with Dr. _____ Please arrive at _____AM/PM.

UPPER GI ENDOSCOPY

Upper GI endoscopy is a special examination of your upper gastro-intestinal (GI) tract for problems like ulcers, foreign objects, or tumors. During the examination a small flexible tube (endoscope) is passed through the mouth to the esophagus, stomach, then to the first portion of the small intestine. The endoscopy can be used to diagnose ulcers, gastritis, tumors, and causes of bleeding and pain. It can also be useful in removing foreign objects (such as coins in children), taking biopsy specimens, removing polyps, and opening narrow areas.

INSTRUCTIONS BEFORE THE PROCEDURE

1. Do not eat anything after midnight the night before the test. You may have clear liquids (see next page) until 3 hours prior to your procedure, unless otherwise instructed.
2. Stop taking Coumadin 4 days prior to procedure, except for patients with a mechanical heart valve, coronary stent placed within the past year or a Deep Vein Thrombosis diagnosed in the past six months.
3. If you are a diabetic, please let your doctor and nurse know so adjustments may be made regarding your insulin or pills.
4. Please bring with you all your medication bottles or a list of medications you are currently taking.

RISKS OF THE PROCEDURE

1. Perforation. During the procedure it is possible, but very uncommon for a tear or small hole to be made in the esophagus or stomach. If a dilatation of the esophagus is necessary the risks of a tear or small hole occurring are increased. Elderly people also have increased risks. A tear or small hole may require hospitalization and possibly surgery. Fortunately, this is a very rare complication.
2. Bleeding. A minor amount of bleeding may occur, however, a large amount of bleeding should be brought to your doctor's immediate attention. Patients that remain on anticoagulants such as Plavix are at increased risk of bleeding You have the option of stopping your anticoagulant 4 days prior to the procedure; however this increases your risk of stroke or blood clots. Any decision to alter your anticoagulant medication should only be done in consultation with your cardiologists or prescribing physician.
3. Medications. As with any medications, allergic reactions or unusual side effects can occur. If you have any known allergies, please be sure to let us know.

THE PROCEDURE

You will have the opportunity to talk with your physician concerning the procedure, prior to sedation. Either the doctor or nurse will answer any questions you may have. You will then be given a sedative and the physician will begin the procedure.

You should plan to spend approximately 60-90 minutes s in our office for preparation, procedure and recovery time.

Your throat may be sprayed with a medication to make it anesthetized or numb. This helps your gag-reflex not be as intense, and therefore, helps the tube pass easier. Intravenous sedation will be given, usually Propofol, Versed or Fentanyl. The endoscope will then be placed in the back of your mouth and you will be asked to swallow. The endoscope does not interfere with breathing. As the doctor begins his examination, some air will be inserted through the endoscope to better visualize the stomach. The procedure itself lasts from 10 to 12 minutes and is generally not painful.

PLEASE BRING SOMEONE WITH YOU TO DRIVE HOME. THIS IS ESSENTIAL, SINCE YOU WILL RECEIVE MEDICATION. YOUR DRIVER SHOULD BE PREPARED TO REMAIN IN THE ENDOSCOPY WAITING AREA DURING YOUR ENTIRE PROCEDURE AND BE AVAILABLE AT THE TIME OF YOUR DISCHARGE.

AFTER THE PROCEDURE

When the procedure is finished you will be asked to stay on your side until your throat is no longer numb. You will then be allowed to rest for a short period of time to allow some of the sedation to wear off, usually 20-30 minutes.

Upon awakening, the nurse will get your family member or driver. The doctor will discuss the test results with you and your family/driver. This is done because the medication has an amnesic effect. If biopsies are taken, the doctor will notify you, usually by phone or letter, in 10-14 days.

You may resume a normal diet after the procedure unless directed otherwise by the doctor or nurse.

You may experience some mild soreness or discomfort following a dilatation of the esophagus, however, should you experience severe chest pain, please notify your doctor immediately.

You may have some soreness of the throat, not lasting longer than 24 hours. Warm salt-water gargles may help this.
Because of the medications you will be given with this procedure, it is imperative that you follow ALL instructions below for the remainder of the day.

1. DO NOT drive a car or operate any machinery.
2. DO NOT drink any alcoholic beverages.
3. DO NOT take any sedatives or other depressant-type medications without first discussing this with your physician.
4. AVOID making important decisions.
5. AVOID signing any legal documents.

The above restrictions apply only to the day of your procedure. You should be able to resume your normal daily activities on the following day. We feel these restrictions are in your best interest, and stress the importance of following them.

Clear Liquids-(No Red Drinks) Only the liquids listed below UP UNTIL 3 Hours BEFORE Procedure.

Black Coffee
7-UP
Tea
Ginger Ale
Jello (No red jello, No fruit added)
Orange Juice (No pulp)
Coke
Gatorade
Water
Apple Juice
Sprite
Mt Dew
Bouillon (chicken or beef)
Popsicles (NO RED)
Pepsi
Dr. Pepper

CONSENT FOR PROCEDURE

I _____ (patient name) give my permission for

the following procedure(s):_____

to be performed by _____(physician) and to receive Intravenous Anesthesia as necessary for the procedure.

I understand the following and agree that my physician has discussed with me:

1. The nature of my illness.
2. The nature and purpose of the procedure.
3. The Benefit(s) of having the procedure.
4. The usual and most likely risks of the procedure including, but not limited to missed polyps, lesions or cancers. This includes the risk that the procedure may not accomplish the goal of the procedure.
5. Diagnostic and therapeutic Alternatives to this procedure.
6. The risk(s) of not performing the procedure.
7. I have had an opportunity to ask all questions and all of my questions have been answered to my satisfaction.
8. No guarantees have been made as to the result of the procedure.
9. I understand that I will need a responsible driver to drive me home and I will not be permitted to ride home unaccompanied in a cab or by other public transportation.

I consent to the administration of Intravenous Anesthesia Medications for my procedure. The risks and complications associated with anesthesia may include allergic reaction, aspiration/pneumonia, respiratory problems, changes in blood pressure, damage to dentition, brain damage, infection, muscle aches, nausea, ophthalmic (eye) injury, pain, positional nerve injury and in very rare cases, death. My questions regarding the nature, purpose and risks of the anesthetic(s), as well as the possibility of complications, have been explained to me. I do understand that although favorable results can be expected, they cannot be and are not guaranteed.

I understand that unexpected events or complications may occur during or following the procedure and that these events/complications may involve additional procedures, treatment, hospitalization, Emergency Room Visit and/or surgery which may result in additional expenses and may be billed to my insurance carrier. I acknowledge and understand I am responsible for any additional charges or fees regardless of insurance coverage. If complications occur, EMS will be called and I will be transferred to the local hospital even if I have an Advanced Directive or a “Do Not Resuscitate” Order. I understand Advanced Directives are not recognized in this facility.

I have the ability to make and communicate my health care decisions.

By signing here, I fully understand the contents of this document and agree to proceed with the procedure.

_____	_____
Patient’s Signature Date	Witness Signature Date
_____	_____
Signature of Authorized Person Date	Physician Signature Date

HYBRID