Cass Regional Medical Center

GI Clinic

OUR CLINIC REQUIRES 72 HOUR NOTICE FOR CANCELLATION DUE TO THE TIME WE ALLOW FOR YOUR APPOINTMENT

You are scheduled with: _____

Appointment Date: _____ Arrival Time: _____

Please complete the enclosed questionnaire along with the medication list.

Bring ALL paperwork with you to your appointment, picture ID and your insurance card.

Report to the Surgery Waiting Room to register for your procedure.

You will be sedated for this procedure. You will **need someone to drive you home and stay with you following your procedure for 24 hours. No mode of public transportation will be allowed, including taxis, buses or walking alone.** Please have your driver with you at check-in to verify your ride.

If having a colonoscopy or flexible sigmoidoscopy, you will need to purchase a bowel prep. See enclosed information.

Helpful Hints:

- Remain at home and close to the bathroom after beginning the prep.
- If you develop nausea or vomiting while drinking the prep solution, take slower sips. Sometimes chilling the liquid and drinking through a straw will help.

If you have any questions, call the GI Clinic at 816-887-0457 between 8:00 a.m. and 3:00 p.m., Monday thru Friday.

Cass Regional Medical Center

Flexible Sigmoidoscopy Prep

OUR OFFICE REQUIRES 72 HOURS NOTICE FOR CANCELLATION DUE TO THE TIME WE ALLOW FOR YOUR **APPOINTMENT**

If you have any questions, call our office at 816-887-0457 between 8:00 a.m. and 3:00 p.m., Monday thru Friday.

You have been scheduled for a Flexible Sigmoidoscopy – Please arrive at: _____

You will need to purchase 4 Fleets Enema's

Your Prep Instructions are as Follows:

1.
   - If you take any blood thinners, please call the GI department (816-887-0457) to determine whether to stop this medication and the time frame to hold. Blood thinners include, but are not limited to the following; Coumadin, Warfarin, Xarelto, Eliquis, Savaysa, Pradaxa, Dipyridomole, Aggrenox, Pletal, Plavix, Ticlopidine, or Effient.
   - If you take **Insulin**, please check with your doctor that prescribes this for you about adjusting your dose prior to your test. **TAKE NO INSULIN OR ORAL DIABECTIC MEDICATIONS THE MORNING OF YOUR TEST.**
   - Stop all **Diet Pills** including over the counter, herbal and prescription 7 days prior to your procedure, this includes Phentermine, Qsymia, ect…
2. Give yourself 2 Fleets Enema's the evening **BEFORE** the procedure.
3. The day before the procedure there are no diet restrictions.
4. DO NOT HAVE ANYTHING FURTHER TO DRINK AFTER MIDNIGHT. If your procedure is at 1:00 p.m. or later, you can drink 6 ounces of water up to 4 hours prior to the procedure.
5. Give yourself 2 more Fleets Enema's 1 hour prior to your arrival time.
6. Please take your scheduled/prescribed medications for heart problems, asthma, pain, anxiety, high blood pressure, breathing problems and seizures, unless otherwise instructed by your physician. Drink only enough water to swallow your pill(s)- no more than 4 fluid ounces.
7. You will be sedated for this procedure. **YOU WILL NEED SOMEONE TO DIEVE YOU HOME, NO MODE OF PUBLIC TRANSPORTATION WILL BE ALLOWD, INCLUDING TAXI'S, BUSES OR WALKING ALONE.** Pleas have your driver with you at Check-In to verify your ride.

   Please bring a list of all the medications you are now taking, including over-the-counter products and herbal supplements.

Cass Regional Medical Center

2800 E. Rock Haven Road, Harrisonville, Missouri 64701

Bring this completed form with you to your appointment.

Name: _____ M F DOB: _____

Height: _____ Weight: _____ Referring Doctor: _____

Previous Test – Last GI Test (Colon, EGD, ERCP, Flex Sig, Barium Enema) Not Applicable _____

Name of Test	Date (Approximate)	Where

Hospitalization/Surgery (exclude normal pregnancies)

Year		Hospitalization/Surgery for:	Year	Hospitalization/Surgery for:

If you have had past problems with anesthetic, including being told you require more medication than normal, please call (816)887-0457.

Habits:

Tobacco (What & how long) _____ _____Packs per day **Alcohol:** Beer Liquor Wine Daily or Occasional

Recreational Drug Use [ ] Yes [ ] No _____

Pregnant [ ] Yes [ ] No Last menstrual period: _____

Family History **Please check the box that applies to each family member.**

	Mother	Father	Siblings
Gallstones			
Ulcers			
Polyps			
Pancreatitis			
Colon Cancer – other Cancer - Specify			
Liver Disease (cirrhosis/Hepatitis)			
Bleeding			

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Bring this completed form with you to your appointment.

Patient Name: _____ DOB: _____

Please √ all that apply.

Respiratory
[ ] Asthma
[ ] Dyspnea
[ ] Sleep Apnea
[ ] COPD
[ ] Cough lasting greater than 3 weeks

Cardiovascular
[ ] Hypertension
[ ] Previous Endocarditis
[ ] Prostatic Heart Valve
[ ] Stroke/TIA
[ ] Pacemaker/ICD
[ ] Rheumatic Heart Disease
[ ] Coronary Artery Disease
[ ] Heart Attack
[ ] Atrial Fibrillation

Gastrointestinal
[ ] Hepatitis
[ ] Diverticulitis/Diverticulosis
[ ] Hiatal Hernia
[ ] Acid Reflux
[ ] Ulcers
[ ] Polyp
[ ] Difficulty Swallowing
[ ] Nausea
[ ] Vomiting
[ ] Diarrhea
[ ] Unintentional Weight Loss
[ ] Cirrhosis

Endocrine/Renal
[ ] Diabetes
[ ] Anemia
[ ] Thyroid (Hyper/Hypo)
[ ] Kidney Failure

Musculoskeletal
[ ] Arthritis
[ ] Joint Replacement within last year
[ ] Muscle Weakness
[ ] Frequent Falls
[ ] Stiffness

Mental Health
[ ] Seizure Disorder
[ ] Depression
[ ] Bipolar
[ ] Head Trauma

Do you have an Advanced Directive? [ ] Yes [ ] No
If no, do you need information? [ ] Yes [ ] No
Do you have a "Medical" Durable Power of Attorney? [ ] Yes [ ] No
If yes, please write the name and phone number. _____

Cass Regional Medical Center

Please bring this completed form with you to your appointment.

Date: _____

Patient Name: _____ Date of Birth: _____

In Order to give the best care possible, a complete list of medications is required. List all medications you take, including dosage, how often or what time(s) of the day you take them. Please include any over the counter herbs, remedies, vitamins, etc. that you may take as well.

Medications; Prescriptions, & Over the counter	Dose	Frequency	Continue	Start	Stop

New Medications:					

Allergies

Patient Signature Date/Time Physicians Signature Date/Time

DISCHARGE INSTRUCTIONS: Manage Your Medications – Keeping an accurate and current medication list is important to your health. Give a list to your Primary Care Provider and take a copy to every to every Physician visit. Update the list whenever there are changes in dose, new medications added or whenever medications are discontinued. Include any change you make in any of your over the counter medications. Carry your current medication list with you at all times.