

## Pre-procedure Information & Instructions for EGD

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

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. Bring all paperwork, picture ID and your insurance card with you. Report to the Surgery Waiting Room to register for your procedure.

You have been scheduled for an Upper GI endoscopy, also called an EGD (esophagogastroduodenoscopy) and is a visual examination of the upper intestinal tract using a lighted video endoscope. The upper gastrointestinal tract starts at the mouth and continues with the esophagus, stomach and then the duodenum, which is a portion of the small intestine.

Doctor: \_\_\_\_\_ Date: \_\_\_\_\_ Time of Arrival: \_\_\_\_\_

#### **PREPERATION:**

- If you have a **morning appointment**, NO FOOD OR WATER AFTER MIDNIGHT. No water, coffee, gum, mints, candy or chewing tobacco. You may brush your teeth but don't swallow any water or toothpaste.
- If you have an **afternoon appointment**, NO FOOD AFTER MIDNIGHT, however YOU MAY DRINK CLEAR LIQUIDS UP TO 7:00 a.m. THE DAY OF YOUR PROCEDURE. After 7:00 a.m. no water, coffee, gum, mints, candy or chewing tobacco. You may brush your teeth but don't swallow any water or toothpaste.
- 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 the dose prior to this procedure. **TAKE NO INSULIN OR ORAL DIABETIC MEDICATIONS THE MORNING OF YOUR PROCEDURE.**
- Stop all **Diet Pills** including over the counter, herbal and prescription 7 days prior to your procedure, this includes Phentermine, Qsymia, ect...
- Please take your scheduled/prescribed medication for heart problems, asthma, pain, anxiety, high blood pressure, breathing problem and seizures, unless otherwise instructed by your physician. Drink only enough water to swallow you pill(s)- no more than 4 fluid ounces.
- Please bring a list of all medications you are now taking, including over-the-counter products and herbal supplements.

You will be sedated for this procedure. **YOU WILL NEED SOMEONE TO DRIVE YOU HOME AND STAY WITH YOU FOLLOWING THE PROCEDURE, 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.



**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			

\*\* If you have and artificial heart valve OR if within the past 12 months have had a joint replacement (such as hip or knee) it is your responsibility to call us for further instructions. (816)887-0457.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Please ✓ all that apply.**

**Respiratory**

- Asthma
- Dyspnea
- Sleep Apnea
- COPD
- Cough lasting greater than 3 weeks

**Musculoskeletal**

- Arthritis
- Joint Replacement within last year
- Muscle Weakness
- Frequent Falls
- Stiffness

**Cardiovascular**

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

**Mental Health**

- Seizure Disorder
- Depression
- Bipolar
- Head Trauma

**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

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. \_\_\_\_\_



Please bring this completed form with you to your appointment.

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

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:	Dose	Frequency	Continue	Start	Stop

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.