BRIGHAM AND
WOMEN'S HOSPITAL
Endoscopy Center

PATIENT INSTRUCTIONS

APPOINTMENT DATE: _____ ARRIVAL TIME: _____

☐ Brigham and Women's
Hospital Endoscopy Center
75 Francis Street
Amory Building, 2nd Floor
Boston, MA 02115

☐ Brigham and Women's
Outpatient Endoscopy Center
850 Boylston Street **(Route 9)**
2nd Floor, Suite 202
Chestnut Hill, MA 02467

PLEASE NOTE THAT THIS IS IN CHESTNUT HILL, NOT BOSTON

If you need to reschedule your appointment, please call the Endoscopy Center at 617-732-7426.
If you have any questions regarding the procedure and preparation, please call our Endoscopy Triage Nurse at 617-525-6814.

YOU ARE SCHEDULED FOR THE FOLLOWING PROCEDURE(S):

☐ **FLEXIBLE SIGMOIDOSCOPY**
☐ **RECTAL MOTILITY**

PLEASE READ NOW AND FOLLOW THESE INSTRUCTIONS ENTIRELY:

Two Weeks Before the Procedure:

- If you take Plavix, Coumadin or any other blood thinning medications please discuss it with the doctor who prescribed it.
- If you are a diabetic, please talk to your doctor or call the endoscopy triage nurse at 617-525-6814 about how to take your medication in order to prevent low blood sugar.

One Week Before the Procedure:

- Do not take iron for at least 5 days prior to your procedure.
- Purchase 2 **Fleet saline enemas** from the pharmacy. No prescription is needed.

The Morning of the Procedure:

- Please use two Fleet saline enemas two hours before you leave for the hospital. Please follow the instructions on the package carefully to ensure a successful test. Once the enemas are given, do not eat until the test has been completed in order to prevent bowel contents moving into the area to be examined.

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Brigham and Women's Endoscopy Center:
Patient Questionnaire

Please bring COMPLETED form with you on the Day of Your Procedure

NAME_____

NAME of person bringing you home _____**Tel#**_____

- **Procedure you are having: Colonoscopy [ ] Sigmoidoscopy [ ] Upper Endoscopy [ ] Other [ ]**
- **Did you take a Prep? yes [ ] no [ ]**
- **If yes, which one Miralax & Dulcolax [ ] GoLytely/NuLytely [ ] Magnesium Citrate [ ] Other [ ]**

Reason for Procedure _____

Current Medications, Prescription / Over the Counter

Medication Name	Dose	Last Time Taken	Medication Name	Dose	Last Time Taken	Medication Name	Dose	Last Time Taken

Personal Medical History

- **Internal Defibrillator yes [ ] no [ ] Difficult Airway Intubation yes [ ] no [ ]**
- **Restricted Neck Movement yes [ ] no [ ] Facial Deformities yes [ ] no [ ]**
- **Glutaraldehyde/Cidex Allergy yes [ ] no [ ] Bleeding Disorder yes [ ] no [ ]**

If you answered YES to any of the above conditions and they were not addressed at the time your procedure was scheduled Please call the Endoscopy Triage Nurse @ 617-525-6814

Personal Medical History Continued

Allergies_____

If checked, please explain

High Blood Pressure	[ ] _____	**Liver Disease**	[ ] _____
Diabetes	[ ] _____	**Kidney Disease**	[ ] _____
Angina/Heart Attack	[ ] _____	**Thyroid Disease**	[ ] _____
Heart Problems	[ ] _____	**Anemia**	[ ] _____
Lung Disease	[ ] _____	**Arthritis**	[ ] _____
Sleep Apnea	[ ] _____	**Cancer**	[ ] _____
Stroke	[ ] _____	**Seizures**	[ ] _____

Other [ ] _____

_____

Surgical History

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please write additional pertinent information you would like to share with us in the space below