MASSACHUSETTS GENERAL HOSPITAL
GASTROENTEROLOGY

Dear Patient,

Thank you for choosing to have your colonoscopy with MGH GI Associates. We are delighted to be able to participate in your healthcare and will make every attempt to make your experience as pleasant and safe as possible. Your colonoscopy appointment and the directions for preparing for your colonoscopy are included with this letter. Please review the directions carefully as soon as you receive this letter as certain items require immediate attention and the preparation itself begins 5 days prior to your procedure.

The most challenging part of having a colonoscopy is preparing for the procedure. Proper bowel preparation (cleansing) is essential to achieving a high quality examination. Any remaining stool in the colon reduces the accuracy of the colonoscopy and increases the chances of missing a significant abnormality. A poor bowel preparation could make it necessary to repeat your colonoscopy or could shorten the time interval before your next colonoscopy.

Included in this packet are:

- *Colonoscopy Preparation Instructions*
- Prescription for NuLYTELY™ or GoLYTELY™ preparation solution
- *Description and Risks of Colonoscopy*
- *Consent to Procedure sample, Patient History form, and Medication List.*
- *Directions to Mass General Digestive Healthcare Center*

If you need to reschedule your colonoscopy, please call your physician's office, the number is provided on the next page. If you have any questions about the preparation for your procedure, please call the Patient Information Line at 617-726-0388 and a nurse will return your call.

I look forward to seeing you at your colonoscopy.

Sincerely,

GI Associates

MASSACHUSETTS GENERAL HOSPITAL
GASTROENTEROLOGY

**Physician:** _____ **Phone Number:** _____
**Patient Name:** _____
**Date of Procedure:** _____ **Time to Arrive:** _____
**Location:** _____

# Preparation Instructions for Colonoscopy - Nulytely/Golytely

Welcome to the MGH GI Endoscopy Unit. We would like to make your stay as pleasant and safe as possible. Please read these instructions carefully before your colonoscopy.

Please plan to spend about 3-4 hours in our unit for your procedure. We will do everything possible to avoid a delay in your procedure, but emergencies may interrupt the schedule. Please check the location of your procedure; we now have 3 sites (MGH-Blake 4, Charles River Plaza-165 Cambridge Street, 9th floor, and Danvers).

BEFORE you start to prepare for your procedure:

Call your insurance company for an insurance referral, if required.

Update your MGH registration information at **1-866-211-6588,** if you have not done so within 6 months.

If you receive sedation, you MUST have an adult escort to take you home after the procedure. Your escort does not have to come with you when you check in but must meet you in the endoscopy unit when you are ready to go home. You are still required to have an adult escort even if you plan to take the T or a taxi home. You are not allowed to drive until the next day. If you don't have an escort on the day of your procedure, your procedure will be CANCELLED and rescheduled.

**If your procedure is scheduled at Charles River Plaza, and you use a CPAP for sleep apnea or oxygen at home or have an implanted defibrillator, please call the doctor's office at the phone number above immediately to reschedule your procedure for Blake 4.**

**FIVE DAYS before your procedure:**
1. Purchase Nulytely or Golytely with the enclosed prescription. If you have constipation or use a laxative even occasionally, purchase Milk of Magnesia.
2. Purchase a simethicone anti-gas product (Gas-X, Mylanta Gas, Maalox Anti-Gas, etc.).
3. If you have diabetes and take medication to control your blood sugar, contact your primary care physician or diabetes doctor for instructions about how to take your diabetes medication while preparing for this procedure.
4. Please do not eat any raw fruits or vegetables for the next 5 days. Cooked fruits and vegetables and nuts are permitted.

**TWO DAYS before your procedure:**
1. Be sure you have the Nulytely or Golytely from your pharmacy.
2. Take 4 tablespoons of Milk of Magnesia at bedtime.

**ONE DAY before your procedure:**
1. Begin a clear liquid diet starting at breakfast. **You may not have any solids today**. A clear liquid diet includes any liquids you can see through, such as water, tea, black coffee, clear broth, apple juice, Gatorade, white grape juice, soda, Jell-O. Do not eat or drink anything red. Do not drink milk or other dairy products. It is important that you drink at least 8 glasses of liquid through the day in addition to the prep to avoid dehydration.
2. Mix the laxative preparation as directed in the package and refrigerate for 2 hours. You may add a flavor pack if enclosed or lemon flavored Crystal Lite.
3. Follow the instructions below for taking the laxative, **not** the instructions included in the preparation package.
   Beginning at 4 pm, drink 8 ounces of the prep solution every 10-15 minutes. Keep drinking the solution on schedule even though the laxative action may not begin for 2-3 hours. If you become nauseated, wait 30 minutes, then resume drinking but taking in smaller amounts. Drinking the solution through a straw can make it more palatable. Chewing gum or sucking on a hard candy or lollipop between doses can help with tolerability. Use baby wipes if your anal area becomes irritated from frequent bowel movements.
4. At 9 pm, take 2 gas tablets with 8 ounces of clear liquid.
5. At 10 pm, take 2 gas tablets with 8 ounce of clear liquid.
6. Please complete the enclosed Patient Medication List and History Form and bring them with you. Read the enclosed sample consent form. You do not need to bring the consent form with you. You will be asked to sign a copy in the procedure area before your procedure.

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**ON THE DAY of your procedure:**

1. **Take all of your usual medicines including medicines for high blood pressure** with a small amount of water. If you take **Coumadin and/or Plavix**, do not stop these unless you are told to. If you take **insulin**, we recommend that you take ½ your usual dose. We will check your blood sugar prior to the procedure.
2. If you have a medical condition requiring antibiotics before or after procedures, we will determine whether they are needed for your colonoscopy.
3. **STOP CLEAR LIQUIDS 4 HOURS BEFORE YOUR PROCEDURE** (except for small amounts of water with medications).
4. Do not chew gum on the day of the procedure.
5. Do not wear jewelry to your procedure other than wedding rings or bring valuables such as electronics. We cannot be responsible for lost valuables.

Please bring these things with you to your procedure:

1. Your completed Patient Medication List and History Form.
2. The name and phone number of your escort.
3. Photo identification
4. Do not wear jewelry other than wedding rings.

**AFTER your procedure:**

1. You will be monitored in the Endoscopy Unit recovery area for approximately one hour.
2. You will receive diet and medication instructions after your procedure.
3. You may return to work the day after the procedure.

**If you have questions about your procedure, call the Patient Information Line at (617) 726-0388 and leave a message. Messages are checked several times a day. A registered nurse will return your call during regular business hours Monday through Friday. If you need to speak with someone at other times please contact your doctor's office. The phone number is listed on the top of the first page of the preparation instruction sheet.**

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# DESCRIPTION AND RISKS OF COLONOSCOPY

Please read this so that you understand the procedure you are about to have and the risks associated with it. Please call if you have any questions about this examination.

## PROCEDURE:

You are to have an examination of your lower gastrointestinal tract (colon). The procedure is performed with a flexible tube (colonoscope) that will be placed into your rectum in order to examine your colon in detail. Tissue may be sampled (biopsy), polyps may be removed, and bleeding sites may be treated to stop bleeding. You will receive sedatives and narcotic pain relievers through an intravenous (i.v.) line. Our goal is to perform colonoscopy as comfortably and safely as possible, but you may experience some discomfort.

## RISKS:

Colonoscopy is considered a safe procedure. However, there are some risks associated with the procedure and with the medications used. The risks associated with the procedure range from minor problems to significant medical problems. Minor problems may include bloating and abdominal cramps. Reactions to the medications used for sedation, such as inflammation of the vein at the IV site, temporary slowing of the heart rate or breathing, or fall in blood pressure may also occur. Occasionally, pain relief is incomplete.

Significant complications occur rarely. Perforation is a potentially serious problem resulting from a tear in the wall of the colon. If this occurs, it is generally treated with hospitalization and antibiotics or surgery. If a polyp is removed, the risk of perforation increases, and bleeding may also occur. With bleeding, blood transfusions as well as other treatments may be needed to stop the bleeding. Rarely, significant bleeding can occur after a biopsy. Other very rare complications can occur, including death.

The colonoscope will usually be passed through the entire colon to the point where it meets the small intestine (cecum). However, at times, only a more limited examination will be done depending on clinical circumstances. Although colonoscopy is a very sensitive and accurate examination, it is possible that an abnormality that is present will not be detected.

## ALTERNATIVES:

Alternatives to colonoscopy include x-ray studies and surgery. Colonoscopy may provide information that cannot be obtained by x-ray and offers the possibility of immediate treatment such as removal of polyps. Surgery to remove polyps carries a considerably higher risk.

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PATIENT IDENTIFICATION AREA

# PATIENT CONSENT TO PROCEDURE

PATIENT:

UNIT NO:

PROCEDURE: **Colonoscopy with possible biopsy or polypectomy**

☐ Right ☐ Left ☐ Both Sides ☐ Not applicable

My doctor has told me and I understand what procedure/surgery I am having done. I understand why I need it, the possible risks (like drug reactions, bleeding, infection, and complications from receiving blood or blood components), and that there is no guarantee of results. My doctor has also explained what might happen to me if I don't have this procedure, other choices I can make instead of having this done, (including choosing no treatment) and what can happen to me if I choose to do something else. I understand that with any procedure, problems could come up that we did not expect. My provider explained to me how he/she prevents infections related to my health. The following additional risks or issues were explained to me:

**Colonoscopy is a procedure for examination of the colon through which biopsies may be taken and polyps removed. Although colonoscopy is generally safe, some infrequent and possibly serious complications may occur. The most common problem is a reaction to one of the drugs given for the purpose of sedation. Some of the complications of conscious sedation include low blood pressure, low oxygen levels, and changes in heart rhythm. More serious complications of colonoscopy are hemorrhage and perforation, which may require hospitalization, blood transfusion, or surgery. These complications are more frequent following polyp removal, but serious problems usually occur in less than one percent of patients. An additional risk of colonoscopy is the possibility that a polyp, lesion or even a cancer could be missed during the examination.**

If procedural sedation will be used during this procedure to control my pain, I understand that this method of pain control has risks. These risks include difficulty breathing that may require breathing support and decreased blood pressure. The most common side effects are nausea and vomiting. In rare cases, there can be allergic reactions or cardiac arrest (stopping of the heart). Lastly, I may have pain, even after using these medications.

Doctor _____ will perform my procedure/surgery.

I understand that Massachusetts General Hospital (MGH) is a teaching hospital. This means that doctors and students in medical, nursing, and related health care professions receive training here and may take part in my procedure/surgery. My doctor will be there for the important parts of my procedure/surgery. My doctor will determine when other providers need to participate in my procedure/surgery and care.

I understand that this procedure/surgery may have educational or scientific value. The hospital may photograph, videotape, or record my procedure/surgery for educational, research, quality and other healthcare operations purposes. Any information used for these purposes will not identify me.

I understand that blood or other samples removed during this procedure may later be thrown away by MGH. These materials also may be used by MGH, its partners, or affiliates for research, education and other activities that support MGH's mission.

I have had the chance to ask questions about the risks, benefits and alternatives to this procedure/surgery. I am happy with the answers I received. I consent to this procedure/surgery.

Date _____ Time _____ AM/PM _____

Signature (patient/health care agent/guardian/family member) (If patient's consent cannot be obtained, indicate reason above.)

I attest that I discussed all relevant aspects of this procedure/surgery, including the indications, risks, and benefits, as compared with alternative approaches, with the patient, and answered his/her questions.

Date _____ Time _____ AM/PM _____

Signature (Physician/Licensed Practitioner)

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PATIENT IDENTIFICATION AREA

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4

# GI ENDOSCOPY UNIT

# PATIENT HISTORY FORM

**Language and Communication:**

What is your primary language? ☐ English ☐ Other_____

What language do you prefer your health care to be discussed in? _____

Do you have problems with your vision? ☐ N ☐ Y

Do you use?: ☐ Glasses ☐ Contact Lenses ☐ Other_____

Do you have?: ☐ Glaucoma ☐ Other_____

Are you legally blind? ☐ N ☐ Y

Do you have problems with your hearing? ☐ N ☐ Y

Do you use hearing aids? ☐ N ☐ Y

**Allergies:**

Do you have any medication Allergies? ☐ N ☐ Y

Please List:_____

Describe your reaction: ☐ Hives ☐ Stomach Upset ☐ Anaphylaxis ☐ Trouble Breathing ☐ Other_____

Do you have a latex sensitivity? ☐ N ☐ Y

Do you have a latex allergy? ☐ N ☐ Y

Describe your reaction: ☐ Hives ☐ Anaphylaxis ☐ Trouble Breathing ☐ Other_____

Do you have a food allergy? ☐ N ☐ Y

Please List:_____

Describe your reaction: ☐ Hives ☐ Stomach Upset ☐ Anaphylaxis ☐ Trouble Breathing ☐ Other_____

**Indication for Procedure:**

Why are you having this procedure performed today?

| | | |
|---|---|---|
| ☐ Routine Screening | ☐ Crohn's Disease | ☐ Reflux (GERD) |
| ☐ Barrett's Esophagus | ☐ Follow Up from Prior Procedure | ☐ Trouble Swallowing |
| ☐ History of Polyps | ☐ Bleeding | ☐ Anemia |
| ☐ Constipation | ☐ Pain | ☐ Other_____ |
| ☐ Diarrhea | ☐ I'm not sure | |

**Nutrition, Height / Weight, Pregnancy Status:** (Inpatient refer to patient Nursing Data Set )

Height? ____ft. ____in. Weight? ____lbs. ____ oz. or Kilograms

Have you had any recent weight changes? ☐ N ☐ Y If yes: ☐ gain _____ loss ____

Do you have dietary restrictions? ☐ N ☐ Y list: _____

Are you pregnant? ☐ Not Applicable ☐ Possibly ☐ N ☐ Y

**Implanted Electrical Device:**

Do you have an implanted electrical device? ☐ N ☐ Y

☐ Pacemaker ☐ Defibrillator ☐ Other_____

**Obstructive Sleep Apnea (OSA), Machine Use:**

Do you have obstructive sleep apnea (OSA)? ☐ N ☐ Y

If yes, do you use CPAP or BIPAP? ☐ N ☐ Y

What are your settings?_____ ☐ Not sure.

Do you use your machine when you are on vacation? ☐ N ☐ Y

MASSACHUSETTS GENERAL HOSPITAL

PATIENT IDENTIFICATION AREA

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4

# GI ENDOSCOPY UNIT

# PATIENT HISTORY FORM

**Surgical History:**
Please list surgical procedures: (list approximate date/year) _____

Do you smoke? ☐ N ☐ Y if yes, packs/day _____
Do drink alcohol? ☐ N ☐ Y if yes, how much? _____
Do you use recreational drugs ☐ N ☐ Y if yes, what? _____ how much? _____

**DO YOU HAVE or HAVE YOU EVER HAD any of the following conditions?**

**Gastrointestinal:** ☐ none
- ☐ Crohns
- ☐ Ulcerative Colitis
- ☐ Diverticulosis
- ☐ Diverticulitis
- ☐ Diarrhea
- ☐ Constipation
- ☐ Lynch Syndrome
- ☐ Gallbladder disease
- ☐ Hepatitis
- ☐ Ulcer
- ☐ Barretts
- ☐ Difficulty swallowing
- ☐ Varices
- ☐ Reflux (GERD)
- ☐ Heartburn
- ☐ Chest Pain
- ☐ Pancreatitis
- ☐ Other _____

**Lung Disease:** ☐ none
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Pneumonia
- ☐ Pulmonary Artery Hypertension
- ☐ Pulmonary Embolus
- ☐ Other _____

**Heart Disease:** ☐ none
- ☐ Hypertension (high blood pressure)
- ☐ Heart Attack
- ☐ Congestive Heart Failure (CHF)
- ☐ Coronary Artery Disease (CAD)
- ☐ Heart Surgery
  - ☐ Bypass
  - ☐ Valve
  - ☐ Stent placement
  - ☐ Angioplasty
- ☐ Atrial Fibrillation (AF)

**Neurological:** ☐ none
- ☐ Stroke
- ☐ Alzheimer's
- ☐ ADD/ADHD
- ☐ Autistic Spectrum
- ☐ Developmental Delay
- ☐ Seizure Disorder
- ☐ Other _____

**Neuromuscular:** ☐ none
- ☐ Parkinson's
- ☐ Muscular Dystrophy
- ☐ Multiple Sclerosis
- ☐ Other _____

**Organ Transplant:**
- ☐ Heart
- ☐ Lung
- ☐ Liver
- ☐ Bone Marrow
- ☐ Kidney

**Vascular:** ☐ none
- ☐ Aortic Aneurysm
- ☐ Peripheral Vascular Disease
- ☐ Blood Clots

**Immune:** ☐ none
- ☐ Recent Chemotherapy
- ☐ Radiation Therapy
- ☐ Other _____

**Orthopedics:** ☐ none
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Joint Replacement
  - ☐ knee ☐ hip
- ☐ Metal screws or plates

**Mental Health:** ☐ none
- ☐ Anxiety
- ☐ Depression
- ☐ PTSD
- ☐ Bi-Polar
- ☐ Schizophrenia
- ☐ Dependancy
  - ☐ Alcohol
  - ☐ Drug
- ☐ Other _____

**Cancer History:** ☐ none
- ☐ Colorectal
- ☐ Prostate
- ☐ Lung
- ☐ Stomach
- ☐ Breast
- ☐ Liver
- ☐ Pancreas
- ☐ Skin
- ☐ Other _____

**Blood Disorders:** ☐ none
- ☐ Hemophilia
- ☐ Leukemia
- ☐ Von Willebrand
- ☐ Other_____

**Kidney/Renal:** ☐ none
- ☐ Kidney failure
  - ☐ Dialysis
  - ☐ Last Dialysis Date: _____

**Endocrine:** ☐ none
- ☐ Diabetes
  - ☐ Diet controlled
  - ☐ Oral medication
  - ☐ Insulin
- ☐ Thyroid disease
- ☐ Other _____

Is there anything else you would like us to know?_____

| | | | |
|---|---|---|---|
| **Form completed by:** | **Patient Signature:**_____ | **Date**_____ | **Time**_____ |
| | **Other Signature:**_____ | **Relationship**_____ | |

Reviewed by:_____ RN Date_____ Time_____