Outpatient Anorectal Manometry Instructions

Please read carefully all the instructions TODAY and at least one week before your procedure and follow the instructions exactly. Failure to do so may result in the need to reschedule your procedure. If you have questions please call 312-926-2425 Monday – Friday, 8:00 am – 4:00 pm. If you need to cancel, please call with at least 72 hours notice.

ABOUT ANORECTAL MANOMETRY
Anorectal Manometry is a test used to assist your physician in the diagnosis and treatment of various rectal disorders such as incontinence and constipation. Anorectal Manometry allows your physician to measure the pressure in the rectum and in the anal sphincters to show how strong the sphincter muscles are and whether they relax as they should when having a bowel movement. It also measures the ability to perceive sensations of fullness in the rectum.

ANORECTAL MANOMETRY PREPARATION
• Before your test, the GI lab nurse will review your medical history, allergies, and current medications. Please complete the patient questionnaires which are attached to this packet and bring them with you to the GI lab on the day of your test.
• You will need to administer 2 Fleet’s enemas (available without a prescription over-the-counter) 2 hours before the test. The rectum needs to be clear of stool to perform an accurate test.
• There are no eating or drinking restrictions prior to the Anorectal Manometry. However, you may wish to eat a light breakfast and/or lunch on the day of your test.

DURING THE ANORECTAL MANOMETRY
Anorectal Manometry takes about 15 minutes to complete. The physician will explain the test and ask you several questions related to the symptoms that you have been experiencing. Then you will be asked to lie on your left side. The physician will perform a rectal exam before starting the Anorectal Manometry test. A thin catheter, which is a flexible plastic tube about the size of a drinking straw will be inserted into the rectum to perform the test. The Anorectal Manometry catheter has a small balloon at the tip which is filled with air. During the test, pressure measurements will be taken. The catheter may be moved around slightly to ensure proper positioning.

During the test you may experience some rectal pressure and/or a feeling of having to have a bowel movement. The physician or technician will ask you to squeeze, relax, and push during the test. During these exercises, the anal sphincter muscle pressures are measured. When squeezing, you will tighten your sphincter muscles as if trying to prevent yourself from having a bowel movement. When pushing, you will bear down as if trying to have a bowel movement. You will also be asked during these exercises if you notice any rectal sensations. In some cases a balloon expulsion test may be performed in which a small balloon at the end of the Anorectal Manometry catheter is inflated and you are asked to try to push the catheter out. Once the Anorectal Manometry is completed, the catheter will be removed and your test will be finished.

AFTER THE ANORECTAL MANOMETRY
The Anorectal Manometry test is usually well tolerated with no serious problems or side effects. Unless instructed otherwise by your physician, after the test, you may resume all normal activities. Your physician will receive the test results usually within 4 business days and will discuss the results with you.
GI LAB PATIENT QUESTIONNAIRE

Refer to Reminder below before completing this form. Thank you for choosing Northwestern Memorial Hospital for your GI Lab procedure. Please fill out this form and bring it with you the day of the procedure.

Please answer each question. This allows us to provide you with the best possible care.

(Please print)

Patient Name ________________________________________________ Date of Birth __________ Date of Procedure __________

Name of Primary Care Physician __________________________ Fax Number __________________

Address __________________________________________________ Phone Number __________________

Procedure and Related Information: * Procedure normally requires sedation

☐ Flexible Sigmoidoscopy ☐ ERCP*

☐ Colonoscopy* ☐ Liver Biopsy*

☐ Upper Endoscopy (EGD)* ☐ Esophageal/Rectal/Small Bowel Manometry

☐ Endoscopic Ultrasound/Fine Needle Aspiration* ☐ 24-hour Ambulatory pH Study

☐ Other ____________________________________________________________

Reason for visit? ____________________________________________________________

Please list the date of your last colonoscopy __________________________ (Month) __________ (Year)

Please list the date of your last upper endoscopy (EGD) ________________________________

When was the last time you ate solid food? Date __________ Time __________________

When was the last time you drank liquid? Date __________ Time __________________

If your test required a bowel preparation, what preparation did you take? __________________________________________________________

Did you complete the preparation? ☐ Yes ☐ No—how much did you complete? __________________________

On the day of your procedure, will you have any of the following: (Please circle) Dentures, Removable Bridgework, Glasses, Hearing Aide, Walker, Cane, Wheelchair, Prosthetics, Other __________________

Family/Friends/Transportation:

Who will be waiting for you during the procedure and/or taking you home afterwards?

Name ________________________________________________ Relationship __________________

Daytime contact number(s) __________________________

Verified by Admitting Nurse __________________________ Date __________ Time __________

Reminder: Per NMH Policy, after receiving any amount of sedation, you MUST have a responsible adult accompany you home after your procedure. You will not be discharged for any reason without an escort.

• If the admitting staff cannot verify your ride home, your procedure will be cancelled.

• You may not walk or take a cab/Uber/CTA home.

• You may not leave the GI Lab unaccompanied for any other appointments you have within NMH.

If your home is within the set service area of Superior Ambulance Company, you may make arrangements for them to take you home for an additional fee (contact Superior for pricing). If you would like to arrange this service, please call 312.926.5988 to make arrangements. Payment will be required at the time of service.

Complete both sides of form
Do you take?

YES  NO
☐ ☐ Sleeping or Anti-anxiety Medications, Sedatives
☐ ☐ Prescribed Anticoagulants, Blood Thinners
☐ ☐ Aspirin or Non-steroidal Anti-inflammatory Drugs
☐ ☐ Insulin or pills to control your blood sugar

Past/Present History:

YES  NO
☐ ☐ Are you currently experiencing pain? ________________ Location __________________________
☐ ☐ Is your pain chronic? __________________________ Location __________________________
☐ ☐ Please rate your pain – 0 (no pain) to 10 (worst pain) __________________________
☐ ☐ Have you or has anyone in your family ever had reactions to the medications given to you during any procedures or surgery? __________________________
☐ ☐ Please describe __________________________
☐ ☐ Allergies (such as drug, food, latex): Please list __________________________
☐ ☐ Reaction __________________________
☐ ☐ Have you experienced a fall in the last 12 months? Please describe __________________________
☐ ☐ Have you ever fainted, felt dizzy or nauseous after having your blood drawn or an IV started? __________________________
☐ ☐ Diabetes: If yes, do you take insulin or pills? __________________________
☐ ☐ Did you take your blood sugar level the day of your procedure? __________________________
☐ ☐ Time taken and results __________________________
☐ ☐ High blood pressure: Is your blood pressure controlled by medication? __________________________
☐ ☐ Do you take antibiotics prior to medical or dental procedures? Antibiotic and dose __________________________
☐ ☐ Heart problems __________________________
☐ ☐ Heart pacemaker, implanted cardiac defibrillator __________________________
☐ ☐ Lung disease: (such as Asthma, Emphysema) __________________________
☐ ☐ Sleep apnea __________________________
☐ ☐ Cancer – Location __________________________
☐ ☐ Kidney disease __________________________
☐ ☐ Neurological problems: (such as seizures) __________________________
☐ ☐ Gastrointestinal disease or symptoms: (such as reflux, Crohn’s Disease, ulcerative colitis) __________________________
☐ ☐ Liver disease: (such as cirrhosis, hepatitis) __________________________
☐ ☐ Glaucoma __________________________
☐ ☐ I smoke/use tobacco products. If NO: Do you have a history of use? (circle one) YES / NO
☐ ☐ If YES or HISTORY: Amount per day __________ For how many years __________
☐ ☐ Alcohol/substance use: How much per day? __________________________ Last drink __________________________
☐ ☐ Have you had a hysterectomy? __________________________
☐ ☐ For women ages 12–50, when was the first day of your last menstrual period? __________________________
☐ ☐ Are you pregnant or trying to become pregnant? __________________________
☐ ☐ Is there a possibility that you might be pregnant? __________________________
☐ ☐ Other (such as arthritis, blood disorders, HIV, infectious diseases, breast feeding) __________________________
☐ ☐ Do you follow a special diet for medical reasons? (For example, gluten-free) __________________________

Please list your surgeries __________________________

Patient
Signature __________________________ Date __________ Time __________

Signature of
Admitting Nurse __________________________ Date __________ Time __________

Reviewed by
Physician Signature __________________________ Date __________ Time __________
Dear Patient,

Please complete the Allergies and Medication sections. A staff member will review this list with you if there are any questions. If you have questions about medications NOT prescribed during today’s visit, please contact your primary care physician.

**ALLERGIES:**  
☐ None (check the box if you do not have any allergies)

**MEDICATIONS:**  
☐ None (check the box if you do not take any medications, vitamins, herbals, etc)

<table>
<thead>
<tr>
<th>DRUG</th>
<th>STRENGTH</th>
<th>DOSE/DOSAGE FORM</th>
<th>FREQUENCY</th>
<th>ROUTE</th>
<th>LAST DOSE TAKEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex. Cardizem CD</td>
<td>180 mg</td>
<td>1 capsule</td>
<td>once a day</td>
<td>by mouth</td>
<td>9 pm last night</td>
</tr>
</tbody>
</table>

Date: ______________________

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**INSTRUCTIONS:**

**Staff:** If, during this visit, the patient was prescribed a new medication for a chronic disease/condition or a change was made to the at-home medication regimen for a chronic disease/condition, complete the patient instructions portion below, instruct the patient regarding additions and/or changes, and provide the patient with a photocopy of this document. After completion, check box below, and file.

☐ Medication instructions were reviewed with the patient. The patient received a photocopy of this medication list.

**Patient:** **START/RE-START taking this at-home medication(s):**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Medication at this Strength:</th>
<th>At this Dose/Dosage Form:</th>
<th>How often: (Frequency)</th>
<th>Route:</th>
<th>Start taking this Medication on:</th>
<th>Date, if any, you should stop taking this medication:</th>
</tr>
</thead>
</table>

**Patient:** **STOP taking this at-home medication:**

STOP taking this Medication at this Strength, Dose/Dosage Form, and Frequency: __________________________________________

STOP taking this Medication on: ______________ / __________ / __________

Additional Comments: __________________________________________

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