Outpatient Colonoscopy Instructions – HalfLytely Prep

| Your procedure is scheduled for _______________, _________________. |
| Please arrive at ______ am/pm in order to register prior to the exam. |
| Plan to spend 3 hours in the GI Lab from start to finish. |

Diagnosis: ________________________________

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 312-695-4452 Monday – Friday, 8:00 am – 4:00 pm. After hours, we can be reached at 773-884-2760. If you need to cancel, you must call with at least 48 hours notice in order to avoid a “no show” fee.

ABOUT THE COLONOSCOPY

This procedure is an endoscopic examination of the colon by a physician. A thin, flexible tube with a video camera at the tip is used to examine the colon. If necessary, a small piece of tissue (biopsy) can be removed for further examination under a microscope. If a polyp is found, it can generally be removed during the procedure. You will be given an intravenous line (I.V.) in the holding area. Immediately before the procedure begins you will receive I.V. medication for sedation. The test will take approximately 30 minutes to complete. You will be returned to the recovery area where you will be monitored for at least one hour after the procedure. Every effort will be made to keep your appointment at the scheduled time, but in medicine, unexpected delays and emergencies may occur and your wait time may be prolonged. We give each patient the attention needed for his or her procedure.

- You may not drive, operate machinery, make important decisions, or return to work for the remainder of the day following your procedure. You may resume normal activities the next day unless the doctor states otherwise.
- You must have a responsible adult to accompany you home after the procedure. This person must pick you up in the GI Lab. If you have another Doctor’s appointment or any other testing at Northwestern Memorial Hospital after your GI Lab procedure, a responsible adult must escort you out of the GI Lab and to your appointment.
- You may not walk, take a taxi, or any public transportation home unless you are accompanied by a responsible adult.
- If our staff cannot confirm that you have made safe plans for discharge after your procedure, your procedure will be cancelled.
- If you need assistance getting home after your GI Lab procedure, you can arrange a ride home with Illinois Medi Car through Superior Ambulance Company by calling 312-926-5988 or 312-832-2000. The service area from the hospital is North to 5600 Bryn Mawr Ave, West to 2400 Western Ave, and South to 47th St. If you have made Illinois Medi Car arrangements for your discharge home, please inform the GI Lab staff on the day of your procedure.
If you are required to pre-certify your procedure with your insurance company, please make certain that you have done so in advance. You should also double check that both Dr. Cohen and Northwestern Memorial Hospital are in your insurance network. If your insurance company requires you to have a referral for your procedure, please bring it with you on the day of your procedure. If you have Medicare, an Advance Beneficiary Notice (ABN) will be presented to you. This form acknowledges that Medicare may deny payment for the colonoscopy which could cause you to become responsible for the cost of the procedure. Please contact Medicare directly with further questions 800-633-4227.

REGARDING MEDICATION

If you are affected by any of the conditions listed below, please follow these instructions carefully.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Check with your physician regarding your dose of insulin and other diabetic medications needed the day before and the day of your procedure. Inform your doctor that you will be on clear liquids the day prior to your procedure. Check your blood sugar frequently while taking the prep solution and the morning of your procedure.</td>
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<tr>
<td>Heart Valve Replacement or History of Endocarditis</td>
<td>Prophylactic antibiotics are no longer recommended for GI procedures according to the guidelines published by the American Heart Association in 2007.</td>
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<tr>
<td>Blood Thinners: Coumadin, Plavix, Pradaxa, Xarelto, Eliquis, Brilanta, Effient, Lovenox</td>
<td>Ask the physician who prescribed your medicine how to take it before and after your procedure. If you cannot contact your physician, call us several days before your exam. If you take Coumadin, you may need a blood test two hours before your exam.</td>
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<tr>
<td>Iron Supplements</td>
<td>It is desirable that iron supplements be held for five days prior to your procedure.</td>
</tr>
</tbody>
</table>

RISKS OF COLONOSCOPY

Although colonoscopy is a safe test, there are inherent risks with all medical procedures. These risks include, but are not limited to: 1) Risk of anesthesia reactions including cardiopulmonary complications. 2) Bleeding. 3) Perforation or puncture of the colon – a rare complication that occurs once in every several thousand procedures. 4) Possibility of an incomplete exam in 1-2% of patients. 5) Possibility of missed or incompletely removed polyps. Although colonoscopy is the best test for detection and removal of polyps, it is not perfect. It is possible for polyps to be missed.

ONE WEEK BEFORE YOUR COLONOSCOPY

For best outcome, avoid eating foods that contain seeds, nuts, hulls, berries, or kernels (such as popcorn, poppy seeds, tomatoes, cucumbers, etc.). However, this instruction is not critical.

TWO DAYS BEFORE YOUR COLONOSCOPY

If you are constipated (i.e. bowel movements every 2-3 days or longer), it is recommended that you drink 10 ounces of Magnesium Citrate laxative two days before the colonoscopy so that the preparation on the day before the colonoscopy is easier and more effective. Magnesium Citrate is available without a prescription at any pharmacy. If you have kidney problems or are on dialysis, do not take Magnesium Citrate.
HALFLYTELY PREPARATION INSTRUCTIONS:

DAY BEFORE YOUR COLONOSCOPY

1. **Today you may not eat any solid foods.** You are to drink only CLEAR LIQUIDS all day long. Clear Liquids include: water, coffee or tea without milk, strained fruit juices without pulp (apple, white grape, cranberry, etc.), carbonated beverages or soda pop, clear broth or bouillon. You may have plain Jello or Popsicles except for any red in color. You may have clear hard candy. If you are diabetic, please follow your usual dietary restrictions with regard to the liquids listed above.
   
   a. Drink one 8 ounce serving of clear liquids EVERY HOUR from the time you rise until you start the HalfLytey at 5 p.m.

   b. Between 4 p.m. and 6 p.m. (as early as possible) take 1 bisacodyl delayed-release tablet with water (this is included in the HalfLytey kit). Do NOT chew or crush the bisacodyl tablet. Do not take the bisacodyl tablet within 1 hour of taking an antacid. You will likely need to go to the bathroom within 1-3 hours of taking the bisacodyl delayed-release tablet.

   c. **If you are scheduled for a morning colonoscopy:** Between 8 p.m. and 10 p.m. (approximately 2 hours after taking the bisacodyl tablet) begin to drink HalfLytey, 8 ounces every 15-20 minutes until the entire 2 liters are consumed. Then drink two 8 ounce glasses of any clear liquid.

   **If you are scheduled for an afternoon colonoscopy:** Between 8 p.m. and 10 p.m. (approximately 2 hours after taking the bisacodyl tablet) drink four 8 ounce glasses of HalfLytey, 1 glass every 15-20 minutes, followed by two 8 ounce glasses of any clear liquid. On the morning of your colonoscopy, about 5-6 hours before the procedure, drink four more 8 ounce glasses of HalfLytey, 1 glass every 15-20 minutes, followed by two 8 ounce glasses of any clear liquid.

   d. In order to perform a successful colonoscopy, the colon must be cleaned of fecal material. This is accomplished using this preparation and will stimulate your colon to purge itself, and result in many trips to the bathroom. You will probably start to have a bowel movement within 1 to 2 hours of taking the laxative. The laxative may cause rapid elimination of stool.

2. **Do not eat or drink anything after Midnight.**

   If your test is scheduled for the afternoon, you may have clear liquids up to 3 hours before the test.
WHAT TO EXPECT ON THE DAY OF YOUR COLONOSCOPY

• You may brush your teeth, but do not swallow any water.
• You may take your usual medications with small sips of water. If you use inhalers, prescription eye drops or nasal sprays, you may take them as you would normally and then bring them with you.
• Please bring your completed GI LAB PATIENT QUESTIONNAIRE and MEDICATION LIST with you (see the last 3 pages of these instructions).
• If you have a colostomy or ileostomy, please bring an extra set of stoma supplies (flange, pouch, etc.) so that your stoma pouch can be replaced following the procedure.
• Wear comfortable clothing that is easy to remove and leave jewelry and any other valuables at home. Your belongings will be stored in a locked coat check room for the duration of your procedure.
• Please limit your visitors to 1 or 2 friends or family members. Visitors are not allowed into the GI Lab with you or into the recovery room. Please speak with one of the GI Lab staff members if you have a special circumstance or request.
• Parking is available at the Huron/St. Clair Garage for a $10.00 rate with a validated ticket for 0-7 hours, 7-24 hours is $24.00. Remember to bring your parking ticket with you for validation.
• Report to the GI Lab on the 4th Floor of the Galter Pavilion, suite 4-104 to check in at the registration desk at the arrival time scheduled by your Doctor’s office:
• You will be required to show a photo ID, verify insurance information, address, phone number, and e-mail address.
• You will be assigned a case number with which your friend or family member will be able to track whether you are still waiting for your procedure, in the procedure room, or in the recovery room.
• If you are concerned that you have been waiting too long after you have checked in, please speak to the front desk staff or a GI Lab staff member.
• You will be brought into the GI Lab where a nurse will review your medical history, current medication list, and that you have taken your preparation appropriately. You will be asked to put on a hospital gown. An intravenous line (IV) will be started for your sedation during the procedure. If you are female, you will be offered a free pregnancy test prior to the procedure, per hospital policy. If you have a history of falling or fainting, please tell the nurse before the IV is placed.

You may be waiting in a gowned waiting room prior to your procedure with other patients. There are many doctors that perform procedures in the GI Lab and many patients that are having a variety of procedures. If you have any concerns about a delay or your exact procedure time, please speak with one of the GI Lab staff members.

• During the procedure, your heart rate, blood pressure and oxygen level will be monitored.
• You will be required to sign a consent form with the doctor prior to your procedure.
• When your procedure is done, you will remain in the recovery room for at least 1 hour.
• You may still experience effects from the sedation, such as being tired and forgetful, for a few hours after your procedure.
• The recovery room nurse will review what you should expect to feel for the remainder of the day. If you had a colonoscopy, this includes feeling some gas pain. If you have had an upper endoscopy, you may have a sore throat.
• After the procedure, you will receive preliminary results and follow-up instructions.
• When you leave the GI Lab, please remember to take all of your belongings and your discharge instructions.
• About 3 days after your procedure, you will receive a patient satisfaction form via e-mail. Please complete this, as your feedback is valuable to our operation.

Please let us know if you will require special assistance while you are in the GI Lab for your procedure. This includes having difficulty with starting IV’s, requiring a language interpreter, requiring assistance with walking, changing clothing, or any other special request please contact the GI LAB Clinical Coordinator at 312-926-7614.
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: ___________

Primary Care Physician: Name ___________________________ Fax Number ___________________________

Address ___________________________ Phone Number ___________________________

Procedure & Related Information: (*) procedure normally requires sedation

☐ Flexible Sigmoidoscopy ☐ Liver Biopsy
☐ Colonoscopy* ☐ Esophageal/Rectal/Small Bowel Manometry
☐ Upper Endoscopy* ☐ 24 Hour Ambulatory pH Study
☐ Endoscopic Ultrasound/Fine Needle Aspiration* ☐ Other:
☐ ERCP*

Reason for visit: __________________________________________________________

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 ___________________________ Relation ________________

Daytime contact number(s) ___________________________ Date ________________ Time ______

Verified by Admitting Nurse ___________________________ Date ________________ Time ______

Reminder: Per NMH Policy, if you are having any type or amount of sedation or anesthesia you must have a responsible adult to accompany you home after the procedure. This person must pick you up in the GI Lab. If you have another doctor’s appointment or any other testing at Northwestern Memorial Hospital after your GI Lab procedure, a responsible adult must escort you out of the GI Lab and to your appointment. You may not walk, take a taxi or any public transportation home unless you are accompanied by a responsible adult. If our staff cannot confirm that you have made safe plans for discharge after your procedure, your procedure will be cancelled. If you will need assistance getting home after your GI Lab procedure, you can arrange a ride home with Illinois Medi Car through Superior Ambulance Company by calling 312.926.5988. Illinois Medi Car Hours of Operation are Monday-Friday: 7:00 am - 7:00 pm. Illinois Medi Car Rates are $30 for the first 10 miles, as a flat rate. Beyond 10 miles, $3.00 per mile will be charged in addition to the $30. You are not expected to pay on the day of service. You will be billed at a later time. Any questions or concerns about a bill from Illinois Medi Car can be directed to Celeste Basom at 630.854.1364. If you have made Illinois Medi Car arrangements for your discharge home, please inform the GI Lab staff on the day of the procedure.
Do you take?

YES  NO
☐ ☐ Sleeping or Anti Anxiety Medications, Sedatives
☐ ☐ Prescribed Anticoagulants, Blood Thinners
      Last Dose Taken (Date ___________ Time ________)
☐ ☐ Aspirin or Non-steroidal Anti-Inflammatory Drugs
☐ ☐ Insulin or pills to control your blood sugar

Please fill out the PATIENT MEDICATION LIST and bring it with you the day of your procedure.

Past/Present History:

YES  NO
☐ ☐ Are you currently experiencing pain?__________________________
      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 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?
      Please describe: __________________
☐ ☐ Diabetes: If yes, do you take insulin or pills?
☐ ☐ Did you take your blood sugar 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____________________
☐ ☐ Smoking/Tobacco Use: How much per day?____________________
☐ ☐ Alcohol/Substance Use: How much per day?____________________ Last Drink __________________
☐ ☐ Are you pregnant - When was your first day of your last Menstrual Cycle?____________________
☐ ☐ Are you breastfeeding?____________________
☐ ☐ Other: (such as arthritis, blood disorders, infectious diseases)____________________
☐ ☐ Do you follow a special diet for medical reasons? (For example, gluten free)____________________

Please list your surgeries: __________________

Have you visited a GI Lab in the past? If so, please list the procedure(s) you have had and the year it took place:

Patient
Signature: _______________________________ Date: _______________________________

Signature of
Admitting Nurse: _______________________________ Date: _______________________________
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)

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<thead>
<tr>
<th>Source</th>
<th>Reaction</th>
<th>Source</th>
<th>Reaction</th>
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<tbody>
<tr>
<td>Example: Penicillin</td>
<td>Hives</td>
<td>3.</td>
<td></td>
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<tr>
<td>1.</td>
<td>4.</td>
<td>2.</td>
<td>5.</td>
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**MEDICATIONS:** □ None (check the box if you do not take any medications, vitamins, herbals, etc)

**DRUG**
List the medications you are taking, include all over-the-counter medicines, vitamins, herbals, minerals, and those you may have held for today's visit.

**STRENGTH**
List the strength of each tablet, capsule, etc.

**DOSE/DOSE FORM**
How many tablets, units, capsules, are you taking at one time?

**FREQUENCY**
How often do you take the medication? (once a day, twice a day, etc.)

**ROUTE**
How are you taking this medication? (by mouth, injection, patch, etc.)

**LAST DOSE TAKEN**
Indicate the date and time you last took the medication.

**Example:**

<table>
<thead>
<tr>
<th>Ex. Cardizem CD</th>
<th>180 mg</th>
<th>1 capsule</th>
<th>once a day</th>
<th>by mouth</th>
<th>9 pm last night</th>
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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 is prescribed for:</th>
<th>Take this Medication at this Strength:</th>
<th>At this Dose/Dose 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>
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**Patient:** **STOP taking this at-home medication:**

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

STOP taking this Medication on: _______ / _______ / _______

Additional Comments: __________________________

Date: __________________________

Do not write below this line - Hospital Staff ONLY

420610 (02/09)