Greg S. Cohen, MD
GI Lab Address
259 East Erie Street, Lavin Family Pavilion ⇦ **go here for the procedure**
16th Floor Reception Area
Chicago, IL 60611 312-695-4452

Outpatient Upper Endoscopy – EGD (Esophago-Gastro-Duodenoscopy) Instructions

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 800-449-4929. **If you need to cancel, you must call with at least 3 business days notice in order to avoid a "no show" fee.**

ABOUT THE UPPER ENDOSCOPY (Esophago-Gastro-Duodenoscopy)

This procedure is a visual examination of the upper digestive tract (esophagus, stomach and duodenum) by a physician. A thin, flexible tube with a video camera at the tip is used to examine the upper GI tract. If necessary, a small piece of tissue (biopsy) can be removed for further examination under a microscope. You will be given an I.V. in the holding area. Immediately before the procedure begins you will receive I.V. medication for sedation. The test will take approximately 15 minutes to complete. After the procedure, you will be returned to the recovery area where you will be monitored for at least hour. 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.

- 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 are unable to have someone accompany you home after your procedure, as a last resort you can arrange a ride home with **Illinois Medi Car** through Superior Ambulance Company by calling **630-832-2000.** Payment for the transport must be provided prior to or at time of service and can be made over the phone at 630-832-2000. The base rate is $30 and the per mile rate is $3. If you have made Illinois Medi Car arrangements for your discharge home, please inform the GI Lab staff on the day of your procedure.

It is your responsibility to check with your insurance company to see if they require authorization prior to performing the procedure, and if required you must forward any insurance forms to our office. For more information on billing procedures see the "Billing and Insurance" page at www.cohengastro.com.

REGARDING MEDICATION

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

Diabetes	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.
Heart Valve Replacement or History of Endocarditis	Prophylactic antibiotics are no longer recommended for GI procedures according to the guidelines published by the American Heart Association in 2007.
Blood Thinners: Coumadin, Plavix, Pradaxa, Xarelto, Eliquis, Savaysa, Brilanta, Effient, Lovenox	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.
Iron Supplements	It is desirable that iron supplements be held for five days prior to your procedure.

RISKS OF UPPER ENDOSCOPY

Although upper endoscopy 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 GI tract – a rare complication that occurs once in every several thousand procedures.

DIET

1. You may eat and drink normally until midnight before your procedure.
2. You may brush your teeth, and have small sips of clear liquids until 3 hours before your procedure, but otherwise **you should not eat or drink anything after midnight the night before your exam.**

WHAT TO EXPECT ON THE DAY OF YOUR UPPER ENDOSCOPY

- Wear comfortable, loose fitting clothing that is easy to step into and out of. Wear flat shoes or tennis shoes. Do not wear jewelry or bring valuables with you.
- In order to perform a successful EGD, you should not eat or drink anything after midnight the night before your exam. Your stomach must be completely empty to get a thorough examination.
- If you have anything removable in your mouth (i.e. dentures or partials) it will have to be removed for the test.
- 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** MEDICATION LIST with you (see the last page of these instructions).
- Wear comfortable clothing that is easy to remove and **leave jewelry and any other valuables at home**.
- Please limit your visitors to 1 or 2 friends or family members. Please speak with one of the GI Lab staff members if you have a special circumstance or request.
- Parking is available in the Lavin Family Pavilion and can be accessed from either Erie Street or Ontario Street. Remember to bring your parking ticket with you for validation.
- Report to the GI Lab on the 16th Floor of the Lavin Family Pavilion 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.
- 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 been fasting 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.
- 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 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.

Northwestern Memorial® Hospital

GI LABORATORY
At-Home Medications List

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)

Source	Reaction	Source	Reaction
Example: Penicillin	*Hives*	3.	
1.		4.	
2.		5.	

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

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	***Physician:*** **Please check if prescribing additions or changes to chronic medications** ***Staff:*** **If checked, refer to Instructions below. If not checked, file list**
Ex. Cardizem CD	*180 mg*	*1 capsule*	*once a day*	*by mouth*	*9 pm last night*	☐
						☐
						☐
						☐
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						☐
						☐

Date:_____

Do not write below this line - Hospital Staff ONLY

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):

Condition Medication is prescribed for:	Take this Medication at this Strength:	At this Dose/Dose Form:	How often: (Frequency)	Route:	Start taking this Medication on:	Date, if any, you should **stop** taking this medication:
					___/____/____	
					___/____/____	

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: _____

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