NORTH FLORIDA SURGERY CENTER
PATIENT INSTRUCTION SHEET FOR ENDOSCOPY PROCEDURES

You have been scheduled for: ☐ Upper Endoscopy (EGD) Date: _____ Time: _____

☐ Colonoscopy Date: _____ Time: _____

It is very important that you follow all instructions listed below. If you have not spoken to a nurse at the Surgery Center 1 week prior to your procedure, you must call (386) 758-8937.

1. Do not eat or drink anything after midnight.
2. Please come to the surgery center with someone to drive you home. **You will not be allowed to drive yourself home after your procedure.**
3. Wear loose, comfortable clothing.
4. Please do not smoke or drink alcohol for 24 hours before and after your procedure.
5. Leave all jewelry and valuables at home unless the insurance department contacts you, then follow their directions.

MEDICATION INSTRUCTIONS:

We will need a list of all current medications that you are taking. It is very important that we know prior to the procedure your current medications, especially those being taken for blood pressure, heart, seizure and breathing problems. The nurse will tell you which ones you should take on the day of your procedure.

Some General Rules are:

1. Stop Blood Thinners 5-7 day prior to your procedure. This includes Coumadin, Warfarin, Plavix, Pletal , Aggrenox, Xarelto, Eliquis, or Pradaxa.
2. Patients on Coumadin and Warfarin will have to have blood drawn on the day prior to the procedure.
3. Stop Aspirin 3 days prior to the procedure.
4. Stop taking arthritis medication such as Motrin, Aleve, Naproxen, Celebrex, one to two days prior to your procedure.
5. Take your heart, blood pressure, seizure and breathing medications on the day of your procedure with a small sip of water, as instructed during your pre-op
6. Bring your inhaler if you use one.
7. Continue to take your regular medication as usual up to the morning of the procedure.

DIABETIC MEDICATIONS:

1. IF YOU ARE TAKING PILLS, DO NOT TAKE ON THE DAY OF YOUR PROCEDURE.
2. IF YOU ARE TAKING INSULIN, TAKE HALF YOUR NORMAL DOSE ON THE DAY **BEFORE** YOUR PROCEDURE AND **DO NOT** TAKE ANY ON THE DAY **OF** YOUR PROCEDURE.
3. DO NOT TAKE LANTUS THE EVENING BEFORE YOUR PROCEDURE.

North Florida Surgery Center

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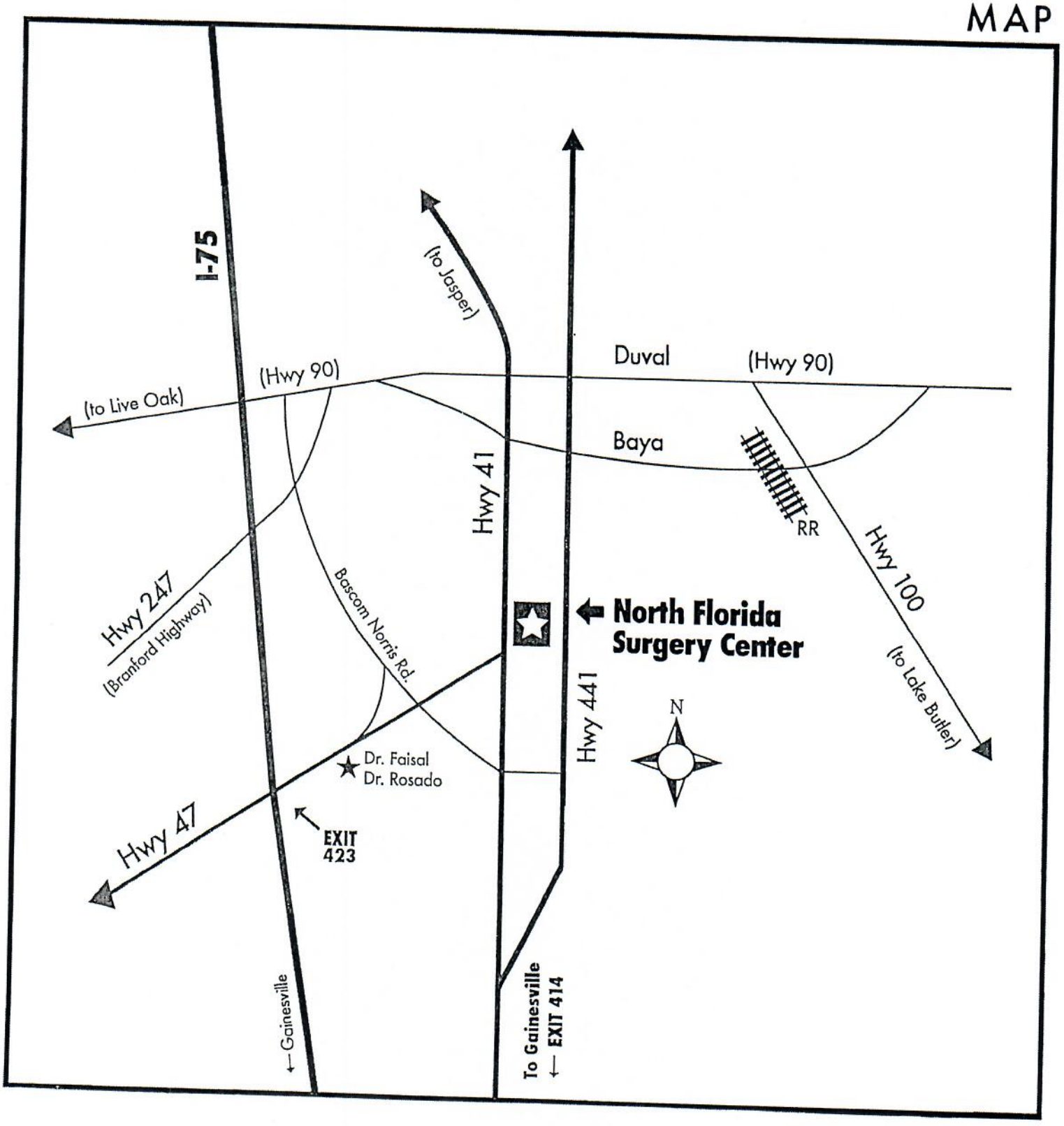
Visit our website for additional information
www.nfsurgerycenter.com

MAP



North Florida Surgery Center Pre-Anesthesia Assessment

Your responses to the following questions will help us determine and provide the anesthetic that is best for you.

(Answer the questions in the shaded areas only)

Drug/Food Allergies:	Age:
	Height:
Latex Allergy? Yes/No	Weight:

(Yes)	(No)	Questions
□	□	Have you recently had a cold or the flu?
□	□	Have you experienced chest pain?
□	□	Do you have a heart condition?
□	□	Do you have high blood pressure (hypertension)?
□	□	Do you experience shortness of breath?
□	□	Do you have asthma, bronchitis or any other breathing problem?
□	□	Do you (or did you) smoke? **IF YES:** Packs per day _____Number of years _____ Date you quit: _____
□	□	Do you consume alcohol? **IF YES**: Drinks/week _____
□	□	Do you take, or have you taken, recreational drugs?
□	□	Have you taken cortisone (steroids) in the last six months?
□	□	Do you take any nonsteroidal, anti-inflammatory Drugs (NSAIDS)?
□	□	Do you take herbal supplements, or complementary or alternative medicines? **IF YES**: How recently? _____
□	□	Do you have diabetes?
□	□	Have you had hepatitis, liver disease, or jaundice?
□	□	Do you have a thyroid condition?
□	□	Do you have, or have you ever had, kidney disease?
□	□	Do you have ulcers or other stomach disorders?
□	□	Do you have a hiatal hernia?
□	□	Do you have neck or back pain?
□	□	Do you have numbness, weakness, or paralysis of your extremities?
□	□	Do you have any muscle or nerve disease?
□	□	HIV positive/AIDS?
□	□	Do you, or any of your family, have sickle cell trait?
□	□	Do you, or any blood relatives, had difficulties with anesthesia?
□	□	Do you have bleeding problems?
□	□	Do you have loose, chipped, or false teeth? Bridgework? Oral piercings (such as studs or rings in your tongue or lip?
□	□	Do you wear contact lenses?
□	□	Have you ever received a blood transfusion?
□	□	***(Women)*** Are you pregnant or could you possibly be pregnant?
□	□	**(*Men*)** Do you take, or have you taken, Viagra, Cialis, or other erectile dysfunction medicines?

Previous surgeries: _____

_____

_____ _____

Signature of person completing form Date

Procedure: □ Colonoscopy □ EGD
□ Ophthalmology: □Right □Left
□ Other: _____

Airway Assessment

Mallampati 1 2 3 4

Heart □ Regular rhythm with no murmurs;
Or: _____

Lungs □ Clear Bilaterally to auscultation;
Or: _____

ROM: □ Full □ Limited □ None

□ Dentures □ Caps, Crowns
□ Overbite □ Loose teeth

Labs

□ Glucose

□ Urine hCG

Medication Review:

□ MAR

□ H&P

Anesthesia Review

□ Patient evaluated / History Reviewed

□ Operative Procedure and Site Verified

□ Discussed and Questions Answered

□ Risks, benefits, and alternatives of anesthesia discussed

□ Consent Obtained

□ NPO >6 hrs □ NPO (other) _____

ASA I II III IV V VI E

Anesthesia Plan (including Potential Anesthesia Problems)

□ GA □ TIVA □ MAC □ Conscious Sedation

□ H&P reviewed, patient assessed; fit for planned anesthesia.

_____ _____
CRNA Date/Time

_____ _____
Surgeon/Physician Date/Time

(Patient Label)

SUPREP

For colonoscopy

DATE OF PROCEDURE:_____

North Florida Surgery Center @_____

Shands Lake Shore @_____

1. **On the day before the procedure** you must be on clear liquids all day.
2. At **6p.m.** pour (1) of the 6-ounce bottles of SUPREP liquid into the mixing container.
3. Mix the solution with cold water to the 16-ounce line on mixing container.
4. **DRINK ALL** the liquid in the container.
5. You must then drink (2) more 16-ounce containers of just water over the next (1) hour.
6. **5 hours before** the procedure time you will repeat steps 2 through 5 using the other 6-ounce bottle of SUPREP liquid. **(Both 6-ounce bottles are required for a complete prep)**
7. You must **NOT** have anything else to drink after completing step 6.
8. You are required to have someone with you to drive you home from the procedure. **You will not be allowed to drive yourself home.**

MEDICATION INSTRUCTIONS

9. **Stop** any Aspirin, Motrin, Aleve, or Ibuprofen 3 days before the procedure.
10. **Stop** any blood thinners **5-7** days prior to your procedure. This includes Coumadin, Warfarin, Plavix, Pletal, and Aggrenox.
11. Patients on **Coumadin** and **Warfarin** must go and have their blood drawn the **day before** the procedure.

Helpful Hints

- If you become sick to your stomach, stop drinking the prep for a couple of hours and rest, then start dinking the prep again. **IT IS IMPORTANT THAT YOU DRINK ALL THE PREP**
- Drinking through straw may be easier.
- Try to include several clear liquids that may be served hot as patients complain of being very cold while preparing for procedure.
- Purchase small container of alcohol free baby wipes to keep the rectal area clean and dry well after each bowel movement.
- You may use over the counter hydrocortisone creams and hemorrhoid treatments as necessary.
- Sitz baths may be necessary if hemorrhoids become irritated.

CLEAR LIQUID DIET

This diet provides fluids that leave little residue and are easily absorbed with minimal digestive activity. This diet is inadequate in all essential nutrients and is recommended only if clear liquids are temporarily needed. **No red liquids should be consumed!**

Food Groups	Allowed	Avoid
Mild & beverages **NO RED LIQUIDS**	Tea (decaffeinated or regular), Carbonated beverages, Fruit flavored drinks	Milk, milk drinks
Meats & meat substitutes	None	All
Vegetables	None	All
Fruits & fruit juices	Strained fruit juices: apple White grape, lemonade	Fruit juices with unstrained fruit
Grains & starches	None	All
Soups	Clear broth, consomme'	All others
Desserts	Clear flavored gelatin, Popsicles (NO RED Flavors)	All others
Fats	None	All
Miscellaneous	Sugar, honey, syrup, Clear hard candy, salt	All others

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