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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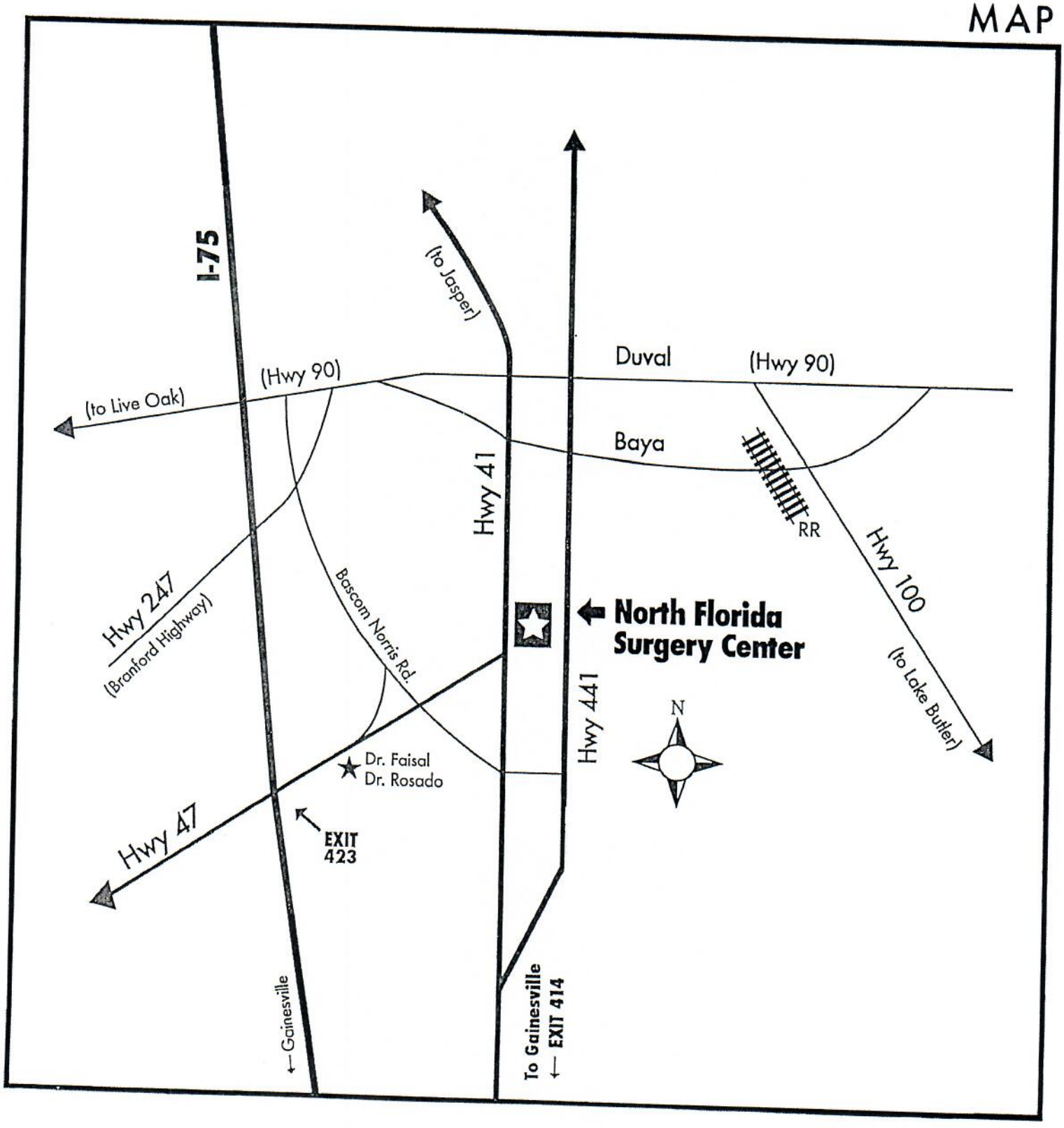
Lake City, FL 32025
386-758-8937

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)