APPOINTMENT DATE _____
ARRIVAL TIME _____

REGISTER AT DEGRAFF MEMORIAL HOSPITAL
445 TREMONT STREET, NORTH TONAWANDA, NY 14120
(716) 694-4500

PLEASE READ THE ATTACHED INSTRUCTIONS UPON RECEIPT. FAILURE TO FOLLOW THE INSTRUCTIONS MAY RESULT IN AN INCOMPLETE TEST OR THE NEED TO RESCHEDULE YOUR PROCEDURE.

THANK YOU FOR YOUR COOPERATION.

PROCEDURE CHECKLIST

□ DRIVER
□ INSURANCE CARDS AND DRIVERS LICENSE/ID. COMPLETED FORMS
□ INFORMATION CARDS FOR IMPLANTED DEVICES SUCH AS PACEMAKER/DEFIBRILLATOR

Upper Endoscopy Instructions

PLEASE READ ALL INSTRUCTIONS ON THE DAY YOU RECEIVE THEM.

About Upper Endoscopy

An upper endoscopy is the examination of the lining of the esophagus, stomach and duodenum using an endoscope. You should plan to be at the hospital for 2-4 hours. It is critical that you follow the instructions as directed.

The physician will discuss results of your procedure with you or your family member when you are in the recovery room. If you had any biopsies taken, you will need to call one week after your procedure for your results. If there are serious findings on the biopsy, your physician will contact you.

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.

If you have any questions or need to cancel, please call (716) 240-2296

What to Bring:

1. The first and last name and address of all doctors you want to receive a copy of your procedure report.
2. Someone to drive you home. Sedation is given during your procedure. **If you have not arranged for someone to drive you home, your procedure will be cancelled.** The person who signs you out must be with you on the unit before you can be released. You will not be able to drive, operate machinery, make important decisions or return to work for the rest of the day. You may resume normal activities the next day unless the doctor states otherwise.
3. Your insurance cards. Some insurance carriers and managed care organizations require preauthorization or precertification. To obtain coverage for these procedures, we recommend you contact your insurance company. Please make sure we have your correct insurance information. If your insurance has changed or is inaccurate, please contact us at (716) 240-2296

Instructions for Upper Endoscopy

Do not consume alcohol the day before your procedure.
Do not eat or drink after midnight the night before your procedure is scheduled, unless you are having a Colonoscopy on the same date, in which case follow the Colonoscopy instructions.

You may drink SIPS OF WATER ONLY with prescribed medications.

Patient Checklist

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

Diabetes	Check with your physician regarding your dose of insulin and other diabetic medications needed the day of your procedure.
Aspirin 81 mg	**Continue to take Aspirin as prescribed by your MD**
Coumadin, Plavix, Heparin, Lovenox or other anticoagulants	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. ***Please do not assume that you can safely follow the same medication adjustments that have been made for your previous procedures.***

What to Wear

Wear comfortable, loose fitting clothing. Wear flat shoes or tennis shoes. Do not wear jewelry or bring valuables.

DO NOT WEAR CONTACT LENSES THE DAY OF YOUR PROCEDURE.

Kaleida Health

DOWNTIME ☐ Entered into electronic record after downtime

date _____ time _____

initials _____

MR-
DOB-
ATT-
PCP-
FC-
Patient ID Area

PT-
AGE- SEX-

ADM DT-

ENDOSCOPIC OUTPATIENT HISTORY 1 of 2

DIRECTIONS: Please fill in this health history and bring it with you on the day of your procedure.

Patient Name: _____

Referring or Primary Care Doctor: _____

Type of procedure: _____

Height: _____ Weight: _____

Allergies *(If you are allergic to LATEX, please notify your physician office PRIOR to the procedure)*: _____

Please (✓) check all that apply:

☐ Heart disease: unstable angina or chest pain

☐ Heart attack, when: _____

☐ Heart surgery, when: _____

☐ Hear murmur/ Heart valve replacement

☐ Pacemaker or Defibrillator (AICD)
please bring manufacturers card

☐ High blood pressure (hypertension)/ Stroke

☐ Lung disease: ☐ asthma ☐ emphysema ☐ bronchitis ☐ cancer

☐ Tuberculosis (TB) or positive TB testing

☐ History of blood clots

☐ Anemia/ Bleeding problems

☐ Multiple sclerosis/ Parkinson's

☐ Epilepsy/ Seizures

☐ Any chance of pregnancy?

☐ Date of last menstrual period: _____

☐ Cataracts/ Glaucoma

☐ Hearing problems

☐ Arthritis/ Gout/ Joint replacement

☐ Gallbladder disease/ Pancreatitis

☐ Liver disease/ Hepatitis

☐ Family history of cancer, who: _____

☐ Personal history of cancer, type: _____

☐ Diabetes

☐ Kidney disease

☐ History of ulcers

☐ Colitis/ Irritable bowel/ Proctitis

☐ Hiatal Hernia/ Reflux

☐ Difficulty swallowing

☐ Weight loss

☐ Hemorrhoids/ Rectal bleeding

☐ Diarrhea

☐ Constipation

☐ Abdominal pain/ Indigestion

☐ Nausea/ Vomiting

☐ Smoking, how much: _____ years: _____

☐ Use of alcohol (ETOH): _____

☐ Do you have any loose or capped teeth?

☐ Other: _____

Do you use blood thinners (anticoagulants), aspirin or aspirin products? ☐ No ☐ Yes, date last used: _____

(continued on back ➡)

Kaleida Health

DOWNTIME ☐ Entered into electronic record after downtime

date _____ time _____

initials _____

MR-
DOB-
ATT-
PCP-
FC-

PT-
AGE- SEX-

ADM DT-

Patient ID Area

ENDOSCOPIC OUTPATIENT HISTORY 2 of 2

CURRENT MEDICATIONS

Please list all current medications including name, dose, how often used (frequency), for what (indication), and last dose taken prior to procedure. Include medications used occasionally. If additional space is needed, please use a separate sheet of paper.

medication name	dose	how often (frequency)	for what (indication)	last dose taken

Please list all previous surgeries and any possible reaction to anesthesia (example, high fever): _____

IF YOU RECEIVE SEDATION FOR YOUR PROCEDURE YOU MUST HAVE A RESPONSIBLE DRIVER TO ACCOMPANY YOU HOME FROM THE HOSPITAL.

_____ _____

Date Patient Signature

_____ _____ _____

Date Time Nurse Reviewed (on day of procedure)

KH01195 Rev. 10/17/07

HISTORY & PHYSICAL