OGDEN CLINIC

Procedure Date:	Procedure Time:
Arrival Time:	Location:

Instructions for Colonoscopy Preparation
-Read Carefully-

PLEASE READ ALL THE INSTRUCTIONS SEVERAL DAYS AHEAD OF TIME SO YOU CAN BE ADEQUATELY PREPARED FOR THIS PROCEDURE.

To ensure your comfort, IV sedation can be given for this exam (to make you relaxed). You must have a responsible companion, family member, or friend, 18 years of age or older escort you to the endoscopy suite, be present during the procedure, be present at the time of you discharge, drive you home, and stay with you for several hours after you procedure. You may not go home alone in a taxi, shuttle van, or bus, as these drivers will not be responsible for you. If you receive sedation, you may not drive until the next day. Please plan to be in our unit approximately 2-3 hour's total.

1 WEEK PRIOR TO EXAM-Purchase the Following
Two (2) 8.3oz (238g) bottles of Miralax powder (over the counter)
Two (2) 64oz Gatorade's *NO RED OR PURPLE COLORS*

SPECIAL MEDICATION INSTRUCTIONS

We recommend you make the following medication changes prior to your procedure:

- **Discontinue any medications FIVE days prior to procedure that contain aspirin (Aspirin, Advil, Aleve, Motrin, Ibuprofen, and Alka Seltzer.) Please call our office if you are taking Coumadin, Plavix, Pain or Arthritis medication. PLEASE NOTE TYLENOL IS NOT RESTRICTED.**
- **Do not take iron pills** for 7 days prior to your procedure.
- **Continue taking your other prescribed medications (e.g. blood pressure pills) as usual.** If you have any questions about your medications, call your prescribing physician.
- **DO NOT** eat nuts or fruits with seeds five days prior to your procedure.
- **Diabetic patients** - Please contact your primary physician for diet and medication instructions.
- If you have an internal defibrillator device **(AICD)**, please bring your card to give to the nurse .You will need to know the name brand of your device prior to your procedure.
- **Are you pregnant?** Bowel cleansing products have not been researched or tested on pregnant women. Please discuss these risks with your OB/GYN.

If you have high blood pressure and are taking medication to monitor this, please look over this list and **DO NOT** take these medications the **NIGHT BEFORE** or the **MORNING OF SURGERY.**

-Accupril	-Enalapril	-Mavik	-Tarka
-Accuretic	-Enalaprilat	-Moexipril	-Trandolapril
-Aceon	-Fosinopril	-Monopril	-Uniretic
-Altace	-Lexxel	-Prinivil	-Vaseretic
-Benazepril	-Lisinopril	-Prinzide	-Vasotec
-Capoten	-Lotensin	-Quinapril	-Zestoretic
-Capozide	-Lotrel	-Ramipril	-Zestril
-Catopril			

Dr. Kyle Dunning, M.D. | 4650 Harrison Blvd. Ogden, UT 84403 | Phone 801.475.3175 | Fax 801.475.3176

COLONOSCOPY PREPARATION INSTRUCTIONS – READ IMMEDIATELY

YOU MUST COMPLETE ALL OF THE PREP NO MATTER HOW CLEAN YOU THINK YOUR COLON IS. THE EXAM CANNOT BE PERFORMED IF YOU COLON IS NOT CLEAN. If your colon is not clean, you may be asked to re-schedule. * If you have constipation problems please ask for the "two-day" prep instructions.*

Two days before your colonoscopy: Low fiber diet and increase fluids.
One day before your colonoscopy: Begin Clear Liquid Diet: ****NO RED OR PURPLE DYES****
Water, Clear broth or bouillon, coffee or tea (no creamer) Gatorade, Propel, Soda, Fruit Juices (no Pulp) Jell-o, popsicles, and hard candies.

PLEASE KEEP YOURSELF HYDRATED by drinking at least 8 glasses of water throughout the day.

FOODS NOT TO EAT/DRINK:

- All solid foods
- Milk or other opaque liquids (liquids you cannot see through)
- Drinks with pulp
- Anything that is RED or PURPLE in color

MORNING BEFORE PROCEDURE: Prepare your Gatorade/Miralax Solution

1. Mix one 64oz Gatorade with 8.3oz Miralax – repeat with 2nd Gatorade and Miralax
2. Begin drinking your 1st prep at 12:00pm
3. Continue drinking clear liquids throughout the day
4. Begin drinking your 2nd prep at 5:00pm
5. REMEMBER NOTHING TO EAT OR DRINK AFTER MIDNIGHT

Most people agree that bowel prep tastes better if chilled. We suggest putting the Prep in the refrigerator.

NOTE: Oral laxatives may cause mild cramping, bloating, or nausea. Always stay near a bathroom while using the Prep Solution.

IF YOU ARE SCHEDULED AT:

McKay Dee Hospital-Enter through the main entrance on the EAST side of the building. Go to the 2nd floor, turn left and go to the endoscopy lab at the end of the hallway.

Ridgeline Endoscopy Center - The facility will contact you the day before your procedure with your arrival time. Ridgeline Endoscopy Center is located at 6028 South Ridgeline Drive, Suite 100, South Ogden, UT 84405. If you have any questions or concerns, please call 801-475-4900.

***** PLEASE NOTE THAT DUE TO A HIGH NUMBER OF CANCELLATIONS, PATIENTS MAY INCUR A FEE OF $100.00 IF THEY CANCEL WITHIN 24 HOURS OF THEIR PROCEDURE OR FAIL TO KEEP THEIR SCHEDULED PROCEDURE.****

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MOUNTAINSTAR

Ridgeline Endoscopy Center

We are pleased that you have chosen Ridgeline Endoscopy Center for your upcoming procedure. We want to be sure that you have all the necessary information to fully prepare for your procedure.

If you have any questions that are not addressed in this packet, please do not hesitate to contact us at 801-475-4900.

Included in this packet you will find:

- **Instructions for your Procedure:** This is information that tells you how to prepare for your upcoming procedure
- **Patient Quick Start Guide for One Medical Passport online registration:** Start your pre-registration on the website, www.onemedicalpassport.com. If you need help completing your online pre-admission, please ask a family member to help you.
- **Medication History form and Patient Interview form:** Only complete the medication history form and Patient Interview form that has been included in your packet if you do not have computer access. Please bring it with you the day of your procedure.

MUST READ

YOU WILL BE SEDATED during your procedure and will not be allowed to drive for 12 hours after so SOMEONE MUST be available to drive you home. If you plan to ride the bus, use "The Ride", or take a taxi, YOU MUST still have a responsible person over the age of 16 to accompany you home. We strive for scheduling consistency. However, due to unexpected findings during procedures, appointment times may run a little further than expected, causing a longer wait time. Feel free to bring reading material to your appointment. Our clinic can be cold at times; you may want to bring a light jacket. Please bring your driver's license and insurance card. Ridgeline Endoscopy does not do the billing for the physician's portion or the lab/pathology fees that may incur during your procedure. These fees are billed separately from the facility fee. It is the patient's responsibility to contact and make payment arrangements for these fees through the appropriate billing service.

SUPPORT SERVICES

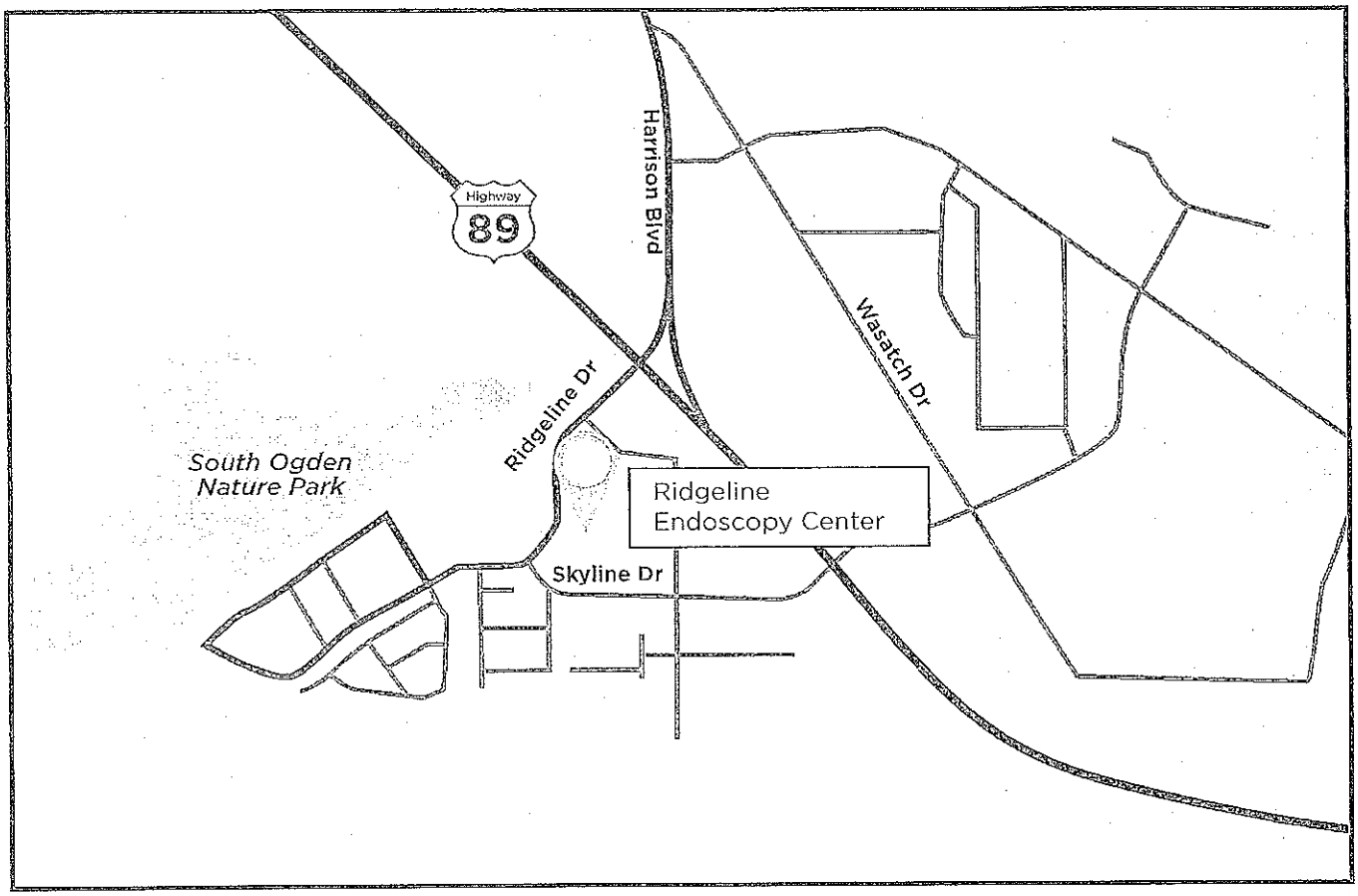
Patient satisfaction is extremely important at Ridgeline Endoscopy Center. Should you have a concern or complaint, please ask to speak to the manager or person in charge. If you do not feel like your concern can be resolved through the facility, you may contact the Utah Department of Health at 1-800-662-4157 or www.cms.hhs.gov/center/ombudsmna.asp to report any concerns or register complaints.

Screening Colonoscopy vs Diagnostic Colonoscopy

If you are scheduled for a screening colonoscopy you may actually end up having a diagnostic procedure. Most insurance companies will only cover a screening as such if you have NEVER had family history, personal history of polyps or cancer, or currently have any signs or symptoms (such as rectal bleeding, change in bowel habits, diarrhea, constipation, abdominal pain etc.). If your doctor finds a polyp or takes a biopsy for ANY reason, all of these will result in a diagnostic procedure. A diagnostic procedure will still be covered by your insurance; however, will be paid as your surgical benefit. Please contact your insurance prior to your procedure and ask for BOTH your screening and diagnostic benefits so that you are well informed. Insurance code states as a provider we are responsible to bill according to what the patient presents at the time of procedure and the findings of the physician.

MOUNTAINSTAR

Ridgeline Endoscopy Center



Ridgeline Endoscopy Center
6028 E. Ridgeline Dr.
Ste. 100
Ogden, UT 84405

Hours:
Monday-Friday | 6:30 am to 4:00 pm
Closed Holidays

Ridgeline Endoscopy Center is accredited by the Accreditation Association for Ambulatory Health Care (AAAHC), the nation's leading accrediting organization of outpatient facilities. Being accredited means that this organization has undergone a rigorous professional scrutiny by highly qualified AAAHC professionals and found to provide quality care. So congratulations; you've made an excellent choice.

Patient Quick Start Guide

Ridgeline Endoscopy Center asks that you **COMPLETE** pre-admission with One Medical Passport. The website guides you to enter your medical history online to help us provide you with the best possible care and minimize long phone interviews and paperwork. It is essential that this be completed **2 business days** prior to your procedure. If you have not heard from us 24 hours prior to your scheduled procedure, you must call 801-409-1031 and confirm your appointment.

Help Completing Pre-Admission

Each page has a **Help** link you may click for assistance. If you need help completing your online pre-admission, please ask a family member to help you. **If you do not have access to a computer, please complete the patient interview form and medication history form that has been included in your packet and bring it with you. Please note:** If you register your information online, you do not have to complete the paperwork provided.

Create Your One Medical Passport Account

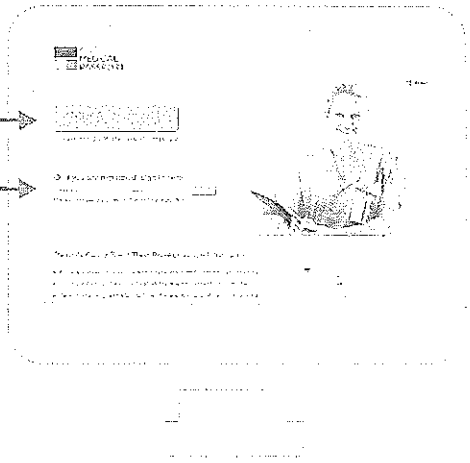
Start your pre-registration on the website, www.onemedicalpassport.com. First time users should click the green **Register** button and create an account. Answer the questions on each page and click save and continue. Once complete, you will be prompted to click **Finish** to securely submit your information. It is not necessary to print your completed registration.

First Time Website Users Click Register

Username you chose: _____

Returning Users (for changes or reuse)

Enter the username and password you chose to access or update your account.



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Ridgeline Endoscopy Center

RIDGELINE ENDOSCOPY CENTER

REV 7/16

Patient Interview Form

Date

E-mail

Patient Name (First Middle Last) | Date of Birth | Gender ◯ M ◯ F | Phone Number | Height (Ft, Inches) | Age | WT.

Primary Symptom | Procedure Date | Surgeon/Doctor | Primary Care Doctor

Immunizations: ☐ Influenza Vaccine (Last 12 months) ☐ Pneumovax Vaccine

Past or Present Medical Conditions — **SCREENING COLONOSCOPY PATIENTS ONLY: PLEASE SKIP THE GASTROINTESTINAL SECTION**

Cardiovascular
- ☐ Chest Pain
- ☐ Abnormal Heart Beat
- ☐ Use of Blood Thinner

Constitutional
- ☐ Weight Loss
- ☐ Fatigue
- ☐ Exercise Intolerance

ENMT
- ☐ Ear Ache / Vertigo
- ☐ Headache
- ☐ Hoarsness
- ☐ Vision Problems
- ☐ Cataracts
- ☐ Glaucoma

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Abdominal Swelling
- ☐ Bloating
- ☐ Blood or Black Stools
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas / Heartburn / Indigestion
- ☐ Jaundice
- ☐ Lack of Bowel Control
- ☐ Nausea/Vomiting
- ☐ Rectal Bleeding
- ☐ Rectal Pain
- ☐ Stomach Cramps
- ☐ Swallowing Difficulties
- ☐ Vomiting Blood
- ☐ History of Polyps
- ☐ C. Difficile Toxin

Genitourinary
- ☐ Lack of Bladder Control / Painful Urination or Burning

Integumentary
- ☐ Rashes or Irritation

Musculoskeletal
- ☐ Arthritis
- ☐ Back Trouble / Pain
- ☐ Joint Pain
- ☐ MS
- ☐ Stiffness

Neurological
- ☐ Numbness or Tingling
- ☐ Weakness or Paralysis

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Nervousness
- ☐ Panic Attacks

Respiratory
- ☐ Shortness of Breath

Other
- ☐ Any Illness, Cold, Cough or Fever Within The Week
- ☐ Asthma
- ☐ Anemia
- ☐ Bleeding /Blood Disorder
- ☐ Broken Bones - Head, Neck, Spine or Restrictions?
- ☐ Cancer
- ☐ Cancer - Breast
- ☐ Cancer - Colon
- ☐ Celiac Disease
- ☐ Colitis
- ☐ Diabetes
- ☐ Difficulty Opening Mouth
- ☐ Diverticulitis
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Hay fever
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Hyperglycemia
- ☐ Hypoglycemia
- ☐ Kidney, Bladder or Prostate Problems
- ☐ Kidney Stones
- ☐ Mental Health Problems
- ☐ Neurological Problems
- ☐ Osteoporosis
- ☐ Recent exposure to any communicable disease
- ☐ Rheumatic Fever
- ☐ Liver Disease
- ☐ Lung Problems
- ☐ Mental Disability
- ☐ Skin Problems
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Stomach Problems
- ☐ Thyroid Disease
- ☐ Tuberculosis / TB
- ☐ Ulcers
- ☐ Other _____

Previous Procedures

Year		Year		Year		Year		Year	
____	Abdominal Surgery	____	Colonoscopy	____	Heart Catheterization/Surgery	____	Nasal/Sinus Surgery	____	Vasectomy
____	Appendectomy	____	Colon Surgery	____	Heart Surgery	____	Plastic Surgery	____	Abdominal CT
____	Breast Growth Removal	____	D and C	____	Hernia Surgery	____	Polyp Removed from Intestine	____	Abdominal Ultrasound
____	Carpal Tunnel	____	EGD	____	Hip Surgery	____	Prostate Surgery	____	Barium Enema
____	Cataract Surgery	____	Gallbladder Removed	____	Hysterectomy	____	Thyroid Surgery	____	UGI Series
____	Cesarean Section	____	Gastric Surgery	____	Knee Surgery	____	Tonsillectomy	____	Flexible Sigmoidoscopy

List Any Trauma / Broken Bones / Serious Accidents And Year They Occurred

Family History

LIST THE CAUSE OF DEATH FOR THOSE WHO HAVE DIED PRIOR TO AGE 50 (DO NOT INCLUDE ACCIDENTIAL DEATHS)

ARE YOU ADOPTED? ◯ Yes ◯ No

Father	Mother's Father	Father's Father
Mother	Mother's Mother	Father's Mother

(Please Turn Over)

(continued)

CHECK ANY ILLNESSES WHICH HAVE OCCURRED IN A BLOOD RELATED BROTHER (B), SISTER (S), MOTHER (M), FATHER (F), GRANDFATHER (GF) or GRANDMOTHER (GM)

Alcoholism/Substance Abuse	☐	M	☐	F	☐	B	☐	S	☐	GF	☐	GM	Crohn's	☐	M	☐	F	☐	B	☐	S	☐	GF	☐	GM
Alzheimer's / Dementia	☐	M	☐	F	☐	B	☐	S	☐	GF	☐	GM	Diabetes	☐	M	☐	F	☐	B	☐	S	☐	GF	☐	GM
Cancer (Brain)	☐	M	☐	F	☐	B	☐	S	☐	GF	☐	GM	Emotional / Mental Illness / Suicide	☐	M	☐	F	☐	B	☐	S	☐	GF	☐	GM
Cancer (Breast)	☐	M	☐	F	☐	B	☐	S	☐	GF	☐	GM	High Blood Pressure	☐	M	☐	F	☐	B	☐	S	☐	GF	☐	GM
Cancer (Colon)	☐	M	☐	F	☐	B	☐	S	☐	GF	☐	GM	Heart Attack Prior to Age 55	☐	M	☐	F	☐	B	☐	S	☐	GF	☐	GM
Cancer (Gastric)	☐	M	☐	F	☐	B	☐	S	☐	GF	☐	GM	Osteoprosis	☐	M	☐	F	☐	B	☐	S	☐	GF	☐	GM
Cancer (Kidney)	☐	M	☐	F	☐	B	☐	S	☐	GF	☐	GM	Polyps	☐	M	☐	F	☐	B	☐	S	☐	GF	☐	GM
Cancer (Prostate)	☐	M	☐	F	☐	B	☐	S	☐	GF	☐	GM	Stroke	☐	M	☐	F	☐	B	☐	S	☐	GF	☐	GM
Cancer (Other)	☐	M	☐	F	☐	B	☐	S	☐	GF	☐	GM	Tuberculosis	☐	M	☐	F	☐	B	☐	S	☐	GF	☐	GM
Colitis	☐	M	☐	F	☐	B	☐	S	☐	GF	☐	GM	Uterine / Ovarian Cancer	☐	M	☐	F	☐	B	☐	S	☐	GF	☐	GM

Social History

Occupation _____ Marital Status _____

◯ Yes ◯ No Do you exercise?

If yes, how often _____

◯ Yes ◯ No Do you use recreational drugs?

If yes, please list _____

◯ Yes ◯ No Do you wear contact Lenses?

◯ Yes ◯ No Do you have physical limitations?

◯ Yes ◯ No Do you need help from your doctor for a problem related to physical, verbal, or mental abuse?

◯ Yes ◯ No Do you have any environmental concerns? (room temperature, lighting, etc.)

◯ Yes ◯ No Are you at risk for AIDS / HIV / (homosexual, bisexual, multiple sex partners, needle drug use other than insulin)?

◯ Yes ◯ No Do you need help from your doctor for an issue related to drugs?

◯ Yes ◯ No Have you traveled outside the US (other than military)?

◯ Yes ◯ No Are you receiving treatment for glaucoma?

Do you have any of the following?

☐ False Teeth ☐ Chipped Teeth ☐ Braces ☐ Bridges

☐ Loose Teeth ☐ Caps/Crowns ☐ Retainers ☐ Body Piercing

Do you have special communication needs?

☐ Vision ☐ Hearing ☐ Language ☐ Speech

Do you smoke? ◯ Yes ◯ No

☐ Smokeless ☐ Cigar ☐ Pipe ☐ Cigarette

Average number of packs per day? _____ Year quit _____

Number of years smoked? _____ Would you like help to quit? ◯ Yes ◯ No

Do you consume alcohol? ◯ Yes ◯ No

If Yes:

How much? _____

How often? _____

Have you ever thought you had a problem with drinking? ◯ Yes ◯ No

Do you consume caffeine? ◯ Yes ◯ No

Advance Directives

◯ Yes ◯ No Do you have a living will?

◯ Yes ◯ No Do you have a durable/special power of attorney?

If yes, where is it located _____

◯ Yes ◯ No Do you have a medical treatment plan?

◯ Yes ◯ No Do you have a Physician Order for life Sustaining Treatment (POLST)?

If yes, where is it located _____

◯ Yes ◯ No Was a copy brought to the facility?

◯ Yes ◯ No Would you like more information?

Please go to http://www.hsdaas.ut.gov for more information on living wills

The conscious sedation medications we use have not been proven to be safe in pregnancy. If you are pregnant or think you might be pregnant, please notify us.

THIS FACILITY WILL NOT BE RESPONSIBLE FOR PERSONAL BELONGINGS AND VALUABLES. AS MANY BELONGINGS AND VALUABLES AS POSSIBLE SHOULD BE TAKEN HOME BY FAMILY MEMBERS.

X _____ _____ _____

PATIENT OR RESPONSIBLE PARTY SIGNATURE DATE RELATIONSHIP

FACILITY USE ONLY

_____ _____

Reviewed By Signature Date

INSTRUCTIONS

- Please NOTE that this is a medication history form that will be used to keep track of current medications you are taking.
- This form can serve as a template medication history if admitted to a healthy care facility.

Patient or Caregiver

1. Please list medications with attention to the entire description. (e.g., note if XR, SR, XL. Are at the end of the medication name). This information can be found on your prescription labels.
2. Please include any medications you are currently prescribed but not taking.
3. Please indicate reasons why not taking these medications.
4. At discharge from this service please keep this with you and share with other Healthcare providers.

Nurse

1. Review the completed Medication History Form with patient and family as part of the overall history.
2. This form will be used to supplement current history forms.
3. Sign in the "reviewed by" signature block.
4. Cross through medications that are discontinued.
5. Contact the practitioner and any related pharmacy services if any compliance issues are noted.

Patient Name:_____ Date of Birth:_____ Today's Date:_____

Medication History Form –please read instructions on back of form prior to filling out

Thank you for choosing Ridgeline Endoscopy Center. A history and physical form and this medication history form are required paperwork and will need to be updated each visit.
Your completed medication history form provides us with the necessary information we need to assure that we are providing a safe and thorough evaluation of your needs. PLEASE FILL IT OUT AND BRING THE COMPLETED FORM WITH YOU TO YOUR APPOINTMENT.

**********An incomplete or blank form could delay your appointment start time**********

☐ Source of Medication List:_____ ☐ NO HOME MEDICATIONS ☐ Unable to obtain medication history [give reason and follow-up plan (i.e. Family bringing in)]	Primary Care Physician: Patient's Home Pharmacy:

Allergies/Reactions ☐ None

☐ LATEX reaction:_____ ☐_____ reaction _____

☐ DEMORAL reaction:_____ ☐_____ reaction _____

☐ EGGS reaction:_____ ☐_____ reaction _____

☐ Has a blood relative had a bad reaction to Anesthesia? Reaction _____ ☐ Have you had a bad reaction to Anesthesia? Reaction _____

Medications on Admissions
INSTRUCTIONS: Include prescriptions, over-the-counter medications, patches, inhalers, vitamins, herbal/home remedies, teas, dietary supplements

Medication [Include dosage form if indicated (EC, XL, ER, SR, CD, XR)]	Dose (amount)	Route (oral, topical, inject, etc)	Schedule (how often you take the med)	When Last Taken Date	When Last Taken Time	Reason for taking (e.g. diabetes, Hypertension, etc.)	Medication Started	Medication Discontinued

BELOW FOR STAFF USE ONLY

Date / Time	Signature	Date / Time	Signature	Date / Time	Signature	Date / Time