one stop
medical center

COLONOSCOPY PREPARATION

Appointment Date: ________________ Time:___________

LOCATION: SOUTHDALE MEDICAL CENTER

6545 FRANCE AVE S. SUITE 290
EDINA, MN 55435

You are scheduled for a colonoscopy, a procedure in which a doctor examines the lining of your large intestine by looking through a flexible tube called a colonoscopy. If growths or other abnormalities are found during the procedure, the doctor may remove the abnormal tissue for closer examination or biopsy.

***Please remember to arrange for a responsible adult to accompany you home. If you do not have a responsible driver, your procedure will be cancelled and rescheduled.**

****A CANCELLATION FEE OF $20 WILL BE BILLED TO YOU IF THIS APPOINTMENT IS NOT CANCELLED AT LEAST 3 DAYS PRIOR TO YOUR APPOINTMENT.**

Review the preparation schedule below for the days preceding your colonoscopy. Should you need further assistance please call 952-922-9999.

Purchase (over the counter):

- **2 tablets bisacodyl** (Dulcolax laxative). These tablets must contain 5 mg of bisacodyl each. Do not use Dulcolax stool softener.
- **1 bottle of Miralax, 8.3 oz** (238 grams)
- **64 oz Gatorade**. No red liquids. Regular Gatorade or Gatorade G2 is acceptable. Refrigerate Gatorade if you wish to drink it cold. Do not substitute: the electrolytes in Gatorade are important for colon preparation. Do not use powdered Gatorade.
- **1 bottle Magnesium Citrate, 10 oz.** No red liquids.

****If you are on Coumadin, you should stop taking this medication 3 days prior to your colonoscopy. You should stop taking Aspirin, Plavix, and NSAIDS 1 week prior to your appointment.**

If you take fiber supplements or medications containing iron, discontinue them 7 days before your appointment. This includes multi-vitamins with iron, Metamucil and Fibercon.

If you have diabetes, ask your regular doctor for diet and medication instructions.

Pregnant or think you may be? Bowel cleaning products have not been researched/ tested on pregnant women. Please discuss risks and benefits of this procedure with your ordering physician.

3 Days before colonoscopy

Begin Low Fiber Diet: No raw fruits or vegetables. No whole wheat or high fiber No nuts or popcorn, No bran or bulking agents. Stop consuming all high fiber foods.
Last day to cancel your appointment OR YOUR WILL BE BILLED A $20 FEE. Please call our office if you need to reschedule your appointment. 952-922-9999

2 Days Prior to colonoscopy

Drink at least 8 glasses of water throughout the day.
No solid foods after midnight.

1 Day Prior to colonoscopy

Begin Clear Liquid Diet ***No red liquids***
Water, clear broth or bouillon, coffee or tea (without milk or non-dairy creamer), Gatorade, Pedialyte, carbonated & non-carbonated soft drinks, Kool-Aid or other fruit-flavored drinks, strained fruit juices (no pulp), Jell-O, popsicles and hard candy. Alcohol is **not** permitted. **Drink** at least 8 glasses of water throughout the day. As a general rule, if you can "see through it" you can drink it!

At 12 noon: Take the two (2) tablets of **bisacodyl** (Dulcolax)

Between 4 and 6 p.m: Mix 1 bottle of **Miralax** (8.3 oz, 238 grams) with 64 oz of **Gatorade** in a large pitcher or bowl. Drink one 8 ounce glass of the solution and continue drinking one 8-oz glass every 15 minutes until the mixture is gone.
If you experience nausea or vomiting, rinse your mouth with water, take a 15 to 30 minute break and then continue drinking the Miralax solution.

***** Oral laxatives may cause mild cramping, bloating or nausea. Always stay near a toilet when using laxatives.**

Procedure Day:

3 hours before your procedure: drink 1 bottle of magnesium citrate (10 oz).
You may take your morning medications.

You may drink clear liquids up to 4 hours before procedure.
Be sure to bring with you:

- Insurance Card
- Pt information sheet
- Colonoscopy recording form
- A driver to take you home

If you have followed the instructions and your stool is no longer formed but clear or yellow liquid, you are ready for the exam. If you are unsure that your colon is clean, please call our office at **952-922-9999**.

Remember you must have a responsible driver to accompany you home.
****You can not drive the remainder of the day after your procedure.**

COLONOSCOPY RECORDING FORM

****PLEASE FILL OUT AND BRING TO YOUR APPOINTMENT!**

PATIENT NAME: ____ AGE: ________ DATE: _______________

COUNSELING PERFORMED _____________________________ REFERRED BY: ________________________

INDICATIONS AND PERSONAL HISTORY:

Rectal Bleeding	Y	N	Black Stools	Y	N
Hemorrhoids	Y	N	Rectal Pain	Y	N
Constipation	Y	N	Diverticular Dx	Y	N
Diarrhea	Y	N	Anemia	Y	N
Change in stool	Y	N	Abdominal Pain	Y	N
Weight Loss	Y	N	Inflam. Bowel Dx	Y	N
Colon Polyps	Y	N	Colon Cancer	Y	N
Abd/Gyn Sugery	Y	N	+ Hemoccult	Y	N
Abnl X-Ray	Y	N	FHcolonCa	Y	N

Who _____________________ Age_____________

OTHER MAJOR MEDICAL HISTORY: ____

MEDICAITONS: ____

ALLERGIES: ____

Flex Sig: _______________________________________Barium Enema: _____________________________

Colonoscopy: ____

Abx for artificial joint/valves: ____

PATIENT DEMOGRAPHICS

TODAY'S DATE______________

*****PLEASE FILL OUT AND BRING TO YOUR APPOINTMENT!!**

PATIENT NAME_____________________________________BIRTHDATE______________AGE______SEX ___M___F

ADDRESS_______________________________________CITY______________________STATE_____ZIP_________

HOME#(____)_____________________CELL#(____)____________________WORK #(____)__________________

SS# __ __ __-__ __-__ __ __ __ MARITAL STATUS ___M___D___S___W

EMPLOYER______________________________EMPLOYERS ADDRESS____________________________________

PRIMARY CARE PHYSICIAN & CLINIC____

EMERGENCY CONTACT____PHONE#___________________________

CONTACTS RELATIONSHIP TO YOU____

E-MAIL_______________________________________REFERRED BY___________________________________

WHERE DID YOU FIND US?____

PRIMARY INSURANCE _______________________ID#________________________GROUP#_______________

INSURED PERSON'S NAME_____________________________ EMPLOYED BY______________________________

SS# __ __ __-__ __-__ __ __ __ DATE OF BIRTH___/___/_____

SECONDARY INSURANCE__________________________ID#___________________________GROUP#_________________

INSURED PERSON'S NAME_________________________________ EMPLOYED BY_________________________

SS# __ __ __-__ __-__ __ __ __ DATE OF BIRTH___/___/_____

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitle, including MEDICARE, private insurance and any other health plans to: One Stop Medical Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. In the event that the patient fails to make payment or there is an outstanding obligation on the account, the patient hereby agrees to be responsible for all court costs and reasonable attorney fees in regards to the collection of this account.

SIGNED____ DATE ____________________________

PATIENT NAME___________________________________ **DATE**________________________

HISTORY OF PRESENT ILLNESS:

Purpose of this visit____

What symptoms are you having? For how long? ____

MEDICAL HISTORY____

MEDICATIONS: List all medications, dosages and times taken per day.

____________________________________ ____

____________________________________ ____

____________________________________ ____

____________________________________ ____

Do you take aspirin? ___Yes ___No How much?____

ALLERGIES: Medications/Foods What was your reaction?

____________________________________ ____

____________________________________ ____

SURGICAL/HOSPITALIZATION HISTORY:

Date of surgery or hospitalization

____________________________________ ____

____________________________________ ____

____________________________________ ____

FAMILY MEDICAL HISTORY:

RELATIONSHIP	Living	Deceased	Age	Diseases
Father	_____	_____	_____	____
Mother	_____	_____	_____	____
Children	_____	_____	_____	____
__________	_____	_____	_____	____
__________	_____	_____	_____	____

SOCIAL HISTORY: **Occupation**____

Cigarettes or tobacco ____Yes ____No How much/how often?________________________________

Alcohol ____Yes ____No How much/how often?________________________________

Drugs ____Yes ____No How much/how often?________________________________

AUTHORIZATION: To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the medical office of any changes in my medical status.

____ ____

Signature of Patient or Guardian Date