

## DAY OF PROCEDURE CHECK LIST

DATE OF PROCEDURE: \_\_\_\_\_ ARRIVAL TIME: \_\_\_\_\_

(If arrival time is 6:30 a.m. – do not come earlier. Our doors open at 6:30 a.m.)

**Please call the office 2 weeks prior to your scheduled appointment to update your information and have your prescription sent to the pharmacy. It is your responsibility to notify the office of ANY and/or ALL changes to your medications, address, phone number, and insurance, as well as an update on weight and height.**

- DID YOU GET WRITTEN PERMISSION AND STOP YOUR BLOOD THINNER PRIOR TO PROCEDURE AS RECOMMENDED BY YOUR PRESCRIBING DOCTOR.**
- DID YOU COMPLETE YOUR PREP**
- DID YOU STOP DRINKING ALL FLUIDS 3 HOURS BEFORE PROCEDURE**
- NO GUM OR MINTS**
- DO YOU HAVE A DRIVER WHO MUST REMAIN IN THE OFFICE WHILE YOU HAVE YOUR PROCEDURE**
- IF YOU ARE A WOMAN OF CHILDBEARING YEARS, DO YOU HAVE A FULL BLADDER TO PROVIDE A URINE SAMPLE**
- DID YOU COMPLETELY FILL OUT YOUR PAPER WORK INCLUDING:**
  - MEDICATIONS**
  - PRIMARY DOCTOR**
  - PRIMARY DOCTOR'S ADDRESS**
  - PRIMARY DOCTOR'S PHONE/FAX #**

## Movi-Prep Colonoscopy Prep Instructions

The prep for your colonoscopy is very important. Unless your colon is cleaned out, the doctor may not be able to see lesions inside your colon. Polyps or cancers could be hidden by stool that is present in the colon. If your prep is not good, your procedure may be aborted and/or rescheduled. It is imperative that you follow your prep instructions to ensure the best possible examination.

Three days prior to your procedure stop eating food that contain alot of fiber (corn, beans, popcorn, tomatoes, or foods with nuts and seeds)

The day prior to your procedure you may eat a light breakfast in the morning. Foods such as yogurt, eggs, plain bread/toast, plain cereal with milk, coffee/tea would be acceptable. **After breakfast, you will then follow a clear liquid diet.** Clear liquids are liquids that you can see through ( apple juice, water,clear sodas). No red/purple liquids and no dairy. We have attached a copy of the clear liquid diet in your prep packet.

Splitting the dose of your laxative will give you the best preparation. Please follow the instructions below on how to take your prep.

### Part 1 of your prep

Date: \_\_\_\_\_

Time: \_\_\_\_\_

- Empty 1 pouch "A" and 1 pouch "B" into the container provided in the kit.
- Add water to the top line of the container, mix until powder is dissolved. You may mix the solution and refrigerate 12 hour ahead of time if you would like.
- MoviPrep container is divided by 4 marks. Drink the solution down to the next mark (approximately 8oz) every 15minutes until the entire container is completed
- After drinking the prep mixture you will need to drink 16oz of any clear liquid of your choice.

### Part 2 of your prep

Date: \_\_\_\_\_

Time: \_\_\_\_\_

- Empty 1 pouch "A" and 1 pouch "B" into the container provided in the kit.
  - Add water to the top line of the container, mix until powder is dissolved. You may mix the solution and refrigerate 12 hour ahead of time if you would like.
  - MoviPrep container is divided by 4 marks. Drink the solution down to the next mark (approximately 8oz) every 15minutes until the entire container is completed
  - After drinking the prep mixture you will need to drink 16oz of any clear liquid of your choice
- Please remember you are not to have anything by mouth 3 hours prior to your procedure time not even gum or mints or your procedure will be canceled.**

If you have any questions about your prep or your procedure, please call our office at any time at 856-848-4464. We will be more than happy to answer any questions you may have about your upcoming appointment.

## CLEAR LIQUID DIET

THIS CLEAR LIQUID DIET IS MEANT TO BE FOLLOWED WHILE YOU ARE PREPARING FOR YOUR COLONOSCOPY. PLEASE FOLLOW THE PACKET OF INSTRUCTIONS YOU HAVE BEEN GIVEN FROM THE OFFICE.

Please remember, **NOTHING** to eat after breakfast the day prior to your colonoscopy. After breakfast you will be following this clear liquid diet.

### LIQUIDS THAT ARE ALLOWED

- > GATORADE
- > JELLO
- > ICED TEA
- > POPSICLES
- > WATER
- > NON-COLA SODA (sprite, ginger ale)
- > HOT COFFEE OR TEA (no cream!!)
- > HARD CANDIES
- > SUGAR (with beverages)
- > APPLE JUICE (not cider)
- > SWEET N LOW, ETC
- > WHITE CRANBERRY JUICE
- > HONEY (in tea)
- > CLEAR CHICKEN OR BEEF BROTH
- > WHITE GRAPE JUICE

### LIQUIDS NOT ALLOWED

- > NO RED, PURPLE PRODUCTS
- > NO ALCOHOLIC BEVERAGES
- > NO ORANGE JUICE OR CITRUS JUICE (if you can not see through the juice you may not have it)
- > ABSOLUTELY NO SOLID FOOD
- > NO MILK OR MILK DRINKS (includes powdered creamer)

### ON THE DAY OF YOUR PROCEDURE

YOU ARE NOT TO DRINK ANYTHING 3 HOURS PRIOR TO YOUR PROCEDURE, NOT EVEN GUM CANDY OR MINTS!!!

YOU SHOULD NOT HAVE HAD ANY SOLID FOOD SINCE YOUR BREAKFAST THE DAY PRIOR TO YOUR TEST **IF THIS IS NOT FOLLOWED YOUR PROCEDURE WILL BE CANCELLED.**

**Please Read the following for additions information prior to your procedure**

Date of procedure: \_\_\_\_\_

Arrival time: \_\_\_\_\_

If your arrival time is 6:30am-do not arrive any earlier. Our doors open at 6:30am

Procedure Time: \_\_\_\_\_

> **All women of child bearing years**-a pregnancy test may be required. If our anesthesiologist determines this test is necessary you may be responsible for the cost of this test. (\$15.00)

> **If you have a defibrillator**-you must notify your cardiologist and get a letter of cardiac clearance for this procedure. We will also need the make and model number of your deibrillator. Please inform the office if you do have this device.

>You **MUST** have someone accompany you the day of your procedure. You will be sedated and **WILL NOT** be permitted to leave here unescorted. This person **MUST** remain here during your procedure. You should be comfortable with this person as they may need to help you with dressing after the procedure. **You and your driver will be required to sign a statement stating that they will remain in the office during your procedure.**

> **STOP BLOOD THINNERS** (i.e coumadin, plavix etc.) 2-5 days prior to your procedure. Your cardiologist will determine the amount of time you need to stop your blood thinner prior to your procedure. **You must get written approval from your doctor that it is permissable for you to stop your medication.** Also, please tell the nurse that you are on these medications before the test starts. If you have any questions/concerns please contact our office.

> **2 days prior to your procedure**: Call our office to confirm your appointment. It is YOUR responsibility to confirm this appointment. We will attempt to contact you 3 days prior to confirm your appointment, but in case we do not reach you, please call us! **Your procedure may be cancelled if we do not confirm your appointment!**

> If you are diabetic, please contact your physician for the amount of medication/insulin to be taken on the day before and the day of your procedure.

**>DO NOT STOP ANY HEART OR BLOOD PRESSURE MEDICATION!** Take them with a small sip of water the morning of your test

> Please bring this packet with you. Please complete all pages in this packet.

**> YOU MAY HAVE CLEAR LIQUIDS UP UNTIL 3 HOURS PRIOR TO YOUR PROCEDURE, AFTER THAT YOU ARE NOT TO HAVE ANYTHING BY MOUTH, THIS INCLUDES GUM, WATER, MINTS!!!!** Food or liquids in the stomach can put you at serious risk for severe complications.

> **IT IS YOUR RESPONSIBILITY TO GET A REFERRAL!** If your insurance requires referrals please obtain one prior to your appointment. A referral is different than a prior-authorization. We will take care of any prior authorization needed. If your insurance requires a facility co-pay, you will be expected to pay this when you arrive the day of your procedure.

If you have any difficulty with your preparation after our office is closed the night before your test, please call **856-573-7543**. This is our answering service. Please let them know you are having a procedure the next day and you are having trouble with your prep. A doctor will return your phone call and give you further instructions.

**PEOPLE'S RIGHTS AS PATIENTS  
PATIENT/CLIENT BILL OF RIGHTS**

DiMarino-Kroop-Prieto Gastro-Intestinal Assoc., P.A. adopts and affirms as departmental policy the following rights of patients/clients who receive services from our directly operated or contracted agencies. This policy affords you, the patient/client, the right to:

1. Be treated with respect, consideration and dignity.
2. Receive, upon request, the name of the person in charge of your care.
3. The name and function of any person providing services to you.
4. Obtain from the person responsible for your health care complete current information concerning your diagnosis, treatment, and expected outlook in terms you can be reasonably expected to understand. When it is not medically advisable to give such information to you, the information will be made available to an appropriate person in your behalf.
5. Receive information necessary to give informed consent prior to the start of any procedure and/or treatment, except for emergency situations. This information shall include as a minimum an explanation of the specific procedure or treatment itself, its value and significant risks, and an explanation of other possible treatment methods, if any.
6. Refuse treatment and to be informed of the medical or other consequences of your action.
7. Privacy to the extent consistent with adequate medical care. Case discussion consultation, examination and treatment are confidential and should be conducted discreetly.
8. Privacy and confidentiality of all records pertaining to your treatment, except as otherwise provided by law or third party contract.
9. A reasonable response to your request for services customarily rendered by this facility, and consistent with your treatment.
10. Expect reasonable continuity of care and to be informed, by the person responsible for your health care, of possible continuing health care requirements following discharge, if any.
11. The identity, upon request, of all health care personnel and healthcare institutions authorized to assist in your treatment.
12. Refuse to participate in research. Human experimentation affecting care or treatment shall be performed only with your informed consent.
13. Upon request, examine and receive an itemized explanation of your bill, regardless of source of payment.
14. Know the facility's rules and regulations that apply to your conduct as a patient.
15. Treatment without discrimination as to race, color, religion, sex, national origin, source of payment, political belief or handicap.
16. Expect that reasonable efforts will be taken to accommodate the rights of the non-smoking patient.
17. Expect your reports of pain to be believed and receive information about pain and pain relief measures, with a concerned staff committed to pain prevention and management and health professionals who respond quickly to reports of pain.
18. Change specialty physician if other qualified physicians are available or request a second opinion.

**To File a Complaint to Medicare:** Medicare Beneficiary Helpline 1-800-6244557 TTY Users 1-800-752-8420 8:30 AM to 5 PM Mon. through Fri.  
[www.medicare.gov](http://www.medicare.gov) Ombudsman

**To File a Complaint about a Health Care Facility:** N.J. Dept. of Health & Senior Services 24 hr. Hotline 1-800-792-9770  
Practice Manager  
Barbara Fagnoli  
Or write to: N.J. Dept. of Health and Senior Services  
Div. Of Health Facilities Evaluation and Licensing  
PO Box 367  
Trenton, N.J. 08625-0367

# SOUTH JERSEY ENDOSCOPY CENTER

26 E. RED BANK AVE, WOODBURY, NJ 08096 · 856-848-4464

## PRE-PROCEDURE PERSONAL INFORMATION FORM

**PLEASE COMPLETE AND BRING THIS PACKET WITH YOU ON THE DAY OF YOUR PROCEDURE**

Patient Name: \_\_\_\_\_ Date of Procedure: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_

### MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	Quantity

- Please attach separate page if needed.

**FEMALES ONLY:** Have you had your menstrual cycle in the last year?  YES  NO

**SOCIAL HISTORY:** Do you smoke:  YES  NO If yes, how many per day: \_\_\_\_\_ How many years: \_\_\_\_\_

**PREP USED:**  Gallon  Half-Lytely  SUPREP  Prepopik  MOVI-Prep  Miralax

Were you able to complete you preparation?  YES  NO  OTHER: \_\_\_\_\_

Do you have any loose, broken or chipped teeth or crowns that are not secure?  YES  NO

Name and phone number of person who will be responsible for accompanying and assisting you with any questions, help in dressing or other assistance as required. Please note: this person **MUST** remain here in our office during your procedure and be able to drive you home: \_\_\_\_\_

Do you give permission for this person to be with you when the doctor goes over your results?  YES  NO

Phone number where you can be reached the business day after your procedure so we may follow-up with your care. \_\_\_\_\_

PRIMARY DOCTOR'S NAME AND ADDRESS: \_\_\_\_\_

South Jersey Endoscopy is owned solely by the Corporation or DiMarino-Kroop-Prieto Gastro-Intestinal Associates, PA.

I have received a copy of the Rights of Patients, Patient Responsibilities and a request for Advance Directive and information of ownership.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**DIMARINO – KROOP – PRIETO GASTRO-INTESTINAL ASSOCIATES, P.A.**

**SOUTH JERSEY ENDOSCOPY CENTER**

26 Red Bank Ave, Woodbury, NJ 08096

856-848-4464

**WAIVER FORM**

Account # \_\_\_\_\_

I realize that my procedure will be performed at SOUTH JERSEY ENDOSCOPY CENTER, AN APPROVED Ambulatory Surgical Center. I understand that my insurance will be billed for both a professional fee from DiMarino-Kroop-Prieto-Gastrointestinal Associates, P.A. and a room fee from South Jersey Endoscopy Center. I will also be receiving MAC anesthesia from an Anesthesiologist which will be billed separately. I also understand that I shall be responsible for any balances that my insurance may not cover, including deductibles and co-pays that may apply if my insurance is not contracted with this Ambulatory Service Center.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**IMPORTANT INFORMATION ABOUT BIOPSIES**

During your procedure, it may be necessary to obtain a biopsy. SOUTH JERSEY ENDOSCOPY CENTER sends all the biopsy specimens to MIRACA DIAGNOSTICS. Miraca participates with all insurance companies. It is possible you will receive an "explanation of benefits" from your insurance company stating that you may receive a bill from Miraca. This is not a bill. We have made special arrangements with Miraca on your behalf, and you should not receive a bill, with the exception of any co-pays or deductibles that would normally be your responsibility. You may be billed from Miraca for that amount, and this would be your responsibility.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE RETURN THIS FORM TO OUR RECEPTIONIST ON THE DAY OF YOUR PROCEDURE. THANK YOU!**



# SOUTH JERSEY ENDOSCOPY CENTER

26 E. RED BANK AVENUE

WOODBURY, NJ 08096

## COLONOSCOPY WITH POSSIBLE POLYPECTOMY CONSENT FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. I hereby authorize Dr. \_\_\_\_\_ to perform the following procedure: \_\_\_\_\_.
2. I understand that during the course of the procedure(s), unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedures than those set forth in paragraph one. I therefore authorize and request that the above-named physician, his/her assistants, or his/her designees perform such procedure(s) as are necessary and desirable in the exercise of their professional judgment.
3. I acknowledge that the available anesthesia options have been explained to me along with the benefits and attendant risks. I consent to the administration of the following type of anesthesia/sedation to be applied by or under the direction of my physician.  
 Moderate Sedation                       Local Anesthesia
4. A physician member of the Anesthesiology Department will obtain consent for any additional anesthesia required. I understand that during the course of a procedure, unforeseen changes in my condition may arise which would necessitate a change in the care being provided to me. Should such an instance arise, I permit the anesthesiologist to provide treatment, which he/she deems necessary for my safety and wellbeing.
5. Dr. \_\_\_\_\_ has fully explained to me the nature and the purpose of the procedure(s), its benefits, possible alternative methods of diagnosis or treatment, the risks involved, possible results of non-treatment. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

*Specifically the risks identified to me include but are not limited to the following: Mild abdominal discomfort, bloating, cramping, irritation, and bruising at the intravenous site. A tear in the wall of the colon that requires urgent surgery occurs in 1 in 2,000 colonoscopies. If a polypectomy is performed, the risk of a tear is 10 in 1,000 and the risk of bleeding is 25 in 1,000. Bleeding rarely occurs following biopsies. Blood transfusions may be necessary. Other complications occurring less than 1 in 2,500 colonoscopies include adverse drug reactions, aspiration of stomach contents, injury to the spleen, and serious problems with heart and lung function. Death has been reported to follow 1 in 5,000*

**DiMARINO-KROOP-PRIETO GASTRO INTESTINAL ASSOCIATES, P.A.**

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Woodbury, NJ 08096  
Phone: 856.848.4464  
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Thomas Jefferson University  
132 South 10<sup>th</sup> Street  
480 Main Building  
Philadelphia, PA 1910  
Phone: (215) 955-8900  
Fax (215) 923-3447

**PROCEDURE CANCELTION/DRIVER AGREEMENT**

I, \_\_\_\_\_, fully understand the verbal and written procedure instructions given to me today. I will contact your office before my procedure if I have any questions about this information or about the consent form.

We will attempt to confirm this appointment 3 days prior to your procedure, however, if we do not reach you personally, **YOU MUST CONFIRM THE APPOINTMENT TWO DAYS PRIOR OR IT MAY BE CANCELLED.**

**YOU MUST ALSO GIVE 48 HOURS NOTICE IF CANCELLING YOUR APPOINTMENT (WEEKENDS DO NOT COUNT IN THE 48 HOURS) OR YOU WILL BE CHARGED \$100.00 CANCELLATION FEE.**

**I agree to inform my driver that he/she MUST drive me here, remain in the waiting room for the entire length of my stay in this facility, and drive me home. The procedure will not start and be cancelled if your driver does not agree to these rules.**

Patient's Signature \_\_\_\_\_

Witness \_\_\_\_\_

Procedure \_\_\_\_\_ Date of Procedure \_\_\_\_\_

Date signed \_\_\_\_\_