Sigmoidoscopy Patient Packet

- INSTRUCTIONS FOR SIGMOIDOSCOPY PREPARATION
- GI LAB PATIENT QUESTIONNAIRE
- GI LABORATORY AT-HOME MEDICATIONS LIST
Instructions for Sigmoidoscopy

APPOINTMENT DATE: ________________ PROCEDURE TIME: ________________

ARRIVE 30 MINUTES before your scheduled procedure time to check in. The GI Lab is located at 675 North St. Clair, Room 4-104, Galter Pavilion. Take the elevators to the 4th floor and check in at the reception desk. Parking is available across the street from the hospital at the parking garage with entrances on Huron or Superior. Be sure to bring your parking ticket with you to be validated.

Please give at least 48-HOUR notice for CANCELING OR RESCHEDULING appointments. For verifying, rescheduling, or canceling a procedure, call 312.573.9626.

Information about Sigmoidoscopy

Sigmoidoscopy is an examination that enables Dr. Kamel to view the lining of the lower one-third of the colon. A sigmoidoscope is a thin flexible tube with a tiny video camera on the end. The sigmoidoscope is inserted through the anus into the lower colon.

Sigmoidoscopy is commonly used to evaluate constipation, diarrhea, bleeding, or any unexplained change in bowel habits. Sigmoidoscopy is more accurate than X-rays for diagnosing inflammation, growths, and potential sources of bleeding.

Complications with sigmoidoscopy are extremely rare.

Sigmoidoscopy Preparation

Complete the GI Lab Patient Questionnaire and GI Laboratory At-Home Medications List forms and bring it with you to the GI Lab on the day of your sigmoidoscopy. Inform Dr. Kamel if you have a history of artificial heart valve replacement, endocarditis, or a systemic-pulmonary shunt since you will require antibiotics prior to your examination.

On the day of your sigmoidoscopy, take all of your routine medications.

You will need to purchase 4 Fleet Enemas® (generic equivalent is fine), which are 4-1/2 ounce, squeeze bottle type enemas, in a green box that are available over the counter at pharmacies.
Begin your bowel preparation approximately 1 hour before leaving your home. There are no dietary restrictions prior to the sigmoidoscopy.

- Lie on your left side with your knees to your chest.
- Remove the enema cap and gently slide the lubricated enema tip through the anus pointing up toward your belly button.
- Gently, but firmly, squeeze the contents of the enema into the rectum and then withdraw the enema tip.
- Hold the liquid as long as possible; 3 to 5 minutes is typical. Then use the washroom.
- Repeat this process with the second and third enemas.
- If the output is clear, you do not need to use the 4th enema.
- If you see stool after the 3rd enema, use the 4th enema.

**During the Flexible Sigmoidoscopy**

Dr. Kamel will explain the sigmoidoscopy and answer any question you may have. You will be asked to lie on your left side while covered with a sheet on an examining table. Dr. Kamel will initially do a rectal examination. The sigmoidoscope will then be inserted into your rectum and slowly advanced through the lower colon. If there are any abnormalities, a biopsy will be obtained which does not cause pain. The sigmoidoscopy usually lasts 5 to 10 minutes. Any discomfort usually comes as a bloated feeling when air is added to the colon to allow for better viewing or as cramping when the sigmoidoscope is advanced around curves of the colon. The sigmoidoscopy is well tolerated.

**After the Flexible Sigmoidoscopy**

Immediately after the sigmoidoscopy, you may experience mild cramping or bloating from the air that was added to the colon. The cramping and bloating will resolve with the passage of gas. You will be able to go about your normal routine after you leave the GI Lab. Dr. Kamel will inform you of your test results after the examination is completed. If biopsy samples are taken, the results will be available in several days and Dr. Kamel will discuss them with you by phone. After leaving the GI Lab, it is important for you to recognize symptoms that need to be reported. These symptoms are severe abdominal pain, fevers (above 100.5°), chills, or significant rectal bleeding. Some scant bleeding may occur if biopsies are done. You will receive discharge instructions; you may call Dr. Kamel if you have any questions or concerns after leaving the GI Lab at the office 312.573.9626 or at 312.649.2952 after office hours.
GI LAB PATIENT QUESTIONNAIRE

Refer to Reminder below before completing this form. Thank you for choosing Northwestern Memorial Hospital for your GI Lab procedure. Please fill out this form and bring it with you the day of the procedure. Please answer each question. This allows us to provide you with the best possible care. (Please Print)

Patient Name: __________________________ Date of Birth: ______________ Date of Procedure: ____________

Primary Care Physician: Name __________________________ Fax Number __________________________

Address __________________________ Phone Number __________________________

Procedure & Related Information: (*): procedure normally requires sedation

☐ Flexible Sigmoidoscopy ☐ Liver Biopsy*
☐ Colonoscopy* ☐ Esophageal/Rectal/Small Bowel Manometry
☐ Upper Endoscopy* ☐ 24 Hour Ambulatory pH Study
☐ Endoscopic Ultrasound/Fine Needle Aspiration* ☐ Other:
☐ ERCP*

Reason for visit? ________________________________________________________________

When was the last time you ate solid food? Date ______________ Time ________

When was the last time you drank liquid? Date ______________ Time ________

If your test required a bowel preparation, what preparation did you take? __________________________

Did you complete the preparation? ☐ Yes ☐ No, how much did you complete? __________________________

On the day of your procedure, will you have any of the following: (Please circle) Dentures, Removable Bridgework,
Glasses, Hearing Aide, Walker, Cane, Wheelchair, Prosthetics, Other __________________________

Do you have any body piercings or tattoos? __________________________

Please describe the last time you fell or experienced a fall: __________________________

Family/Friends/Transportation:
Who will be waiting for you during the procedure and/or taking you home afterwards?

Name __________________________ Relation __________________________

Daytime contact number(s) __________________________

Verified by Admitting Nurse __________________________ Date ______________ Time ________

Reminder: Per NMH Policy, if you are having any type or amount of sedation or anesthesia during your procedure, you must have a responsible adult assist you in getting home safely after your procedure. We advise you to have a friend or family member come with you and wait until your procedure is complete. The sedative medication given in the GI lab may affect you up to 24 hours. Walking, taking a bus, or a train alone (without a friend or family member) is not allowed per the policy, even if you live close to the Hospital. If we cannot confirm that you have made safe plans for discharge after your procedure, your procedure will be cancelled. Please call 312.926.7614 if you have any questions or need help arranging a ride home after your procedure.

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Complete both sides of form
Do you take?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Sleeping or Anti Anxiety Medications, Sedatives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Prescribed Anticoagulants, Blood Thinners</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Last Dose Taken (Date_______Time_______)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Aspirin or Non-steroidal Anti-Inflammatory Drugs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Insulin or pills to control your blood sugar</td>
</tr>
</tbody>
</table>

Please fill out the PATIENT MEDICATION LIST and bring it with you the day of your procedure.

Past/Present History:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

Are you currently experiencing pain?________________________________________
Is your pain chronic? ___________________________ Location _______________________
Please rate your pain - 0(no pain) to 10(worst pain)_____________________________

Have you ever had reactions to the medications given to you during any procedures or surgery? Please describe: ____________________________________________________________

Allergies (such as drug, food, latex) Please list ______________________________________________________________________
Reaction _____________________________________________________________________

Have you ever fainted, felt dizzy or nauseous after having your blood drawn or an IV started? Please describe: ____________________________________________________________

Diabetes: If yes, do you take insulin or pills? ______________________________________
Did you take your blood sugar the day of your procedure?_____________________________
Time taken and results __________________________________________________________

High blood pressure: Is your blood pressure controlled by medication?_________________

Do you take antibiotics prior to medical or dental procedures? Antibiotic and dose __________

Heart Problems ________________________________________________________________
Heart pacemaker, implanted cardiac defibrillator____________________________________
Lung disease: (such as Asthma, Emphysema) ________________________________________
Sleep Apnea __________________________________________________________________
Cancer - Location __________________________________________________________________
Kidney Disease __________________________________________________________________
Neurological Problems: (such as Seizures) __________________________________________
Gastrointestinal Disease or Symptoms: (such as Reflux, Crohn’s Disease, Ulcerative Colitis) _________
Liver Disease: (such as cirrhosis, hepatitis) _________________________________________
Glaucoma ______________________________________________________________________
Smoking/Tobacco Use: How much per day? ___________________________________________
Alcohol/Substance Use: How much per day? __________ Last Drink______________________
Are you pregnant - When was your first day of your last Menstrual Cycle? ___________
Are you breastfeeding? ___________________________________________________________
Other: (such as arthritis, blood disorders, infectious diseases) __________________________
Do you follow a special diet for medical reasons? (For example, gluten free)___________

Please list your surgeries: ____________________________________________________________________________________________

Have you visited a GI Lab in the past? If so, please list the procedure(s) you have had and the year it took place: ________________________________________________________________

Patient Signature: __________________________________ Date: ________________________

Signature of Admitting Nurse: __________________________________ Date: ________________________
Dear Patient,

Please complete the Allergies and Medication sections. A staff member will review this list with you if there are any questions. If you have questions about medications NOT prescribed during today’s visit, please contact your primary care physician.

**ALLERGIES:**  [ ] None (check the box if you do not have any allergies)

<table>
<thead>
<tr>
<th>Source</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Penicillin</td>
<td>Hives</td>
</tr>
<tr>
<td>1.</td>
<td>3.</td>
</tr>
<tr>
<td>2.</td>
<td>4.</td>
</tr>
</tbody>
</table>

**MEDICATIONS:**  [ ] None (check the box if you do not take any medications, vitamins, herbals, etc)

<table>
<thead>
<tr>
<th>DRUG</th>
<th>STRENGTH</th>
<th>DOSE/DOSAGE FORM</th>
<th>FREQUENCY</th>
<th>ROUTE</th>
<th>LAST DOSE TAKEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex. Cardizem CD</td>
<td>180 mg</td>
<td>1 capsule</td>
<td>once a day</td>
<td>by mouth</td>
<td>9 pm last night</td>
</tr>
</tbody>
</table>

**INSTRUCTIONS:**

Staff: If, during this visit, the patient was prescribed a new medication for a chronic disease/condition or a change was made to the at-home medication regimen for a chronic disease/condition, complete the patient instructions portion below, instruct the patient regarding additions and/or changes, and provide the patient with a photocopy of this document. After completion, check box below, and file.

Medication instructions were reviewed with the patient. The patient received a photocopy of this medication list.

**Patient: START/RE-START taking this at-home medication(s):**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Medication is prescribed for:</th>
<th>Take this Medication at this Strength:</th>
<th>At this Dose/Dose Form:</th>
<th>How often: (Frequency)</th>
<th>Route:</th>
<th>Start taking this Medication on:</th>
<th>Date, if any, you should stop taking this medication:</th>
</tr>
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<tbody>
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</tbody>
</table>

**Patient: STOP taking this at-home medication:**

STOP taking this Medication at this Strength, Dose/Dose Form, and Frequency: ________________________________

STOP taking this Medication on: ________ / ______ / ________

Additional Comments: __________________________

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