Perry L. Kamel, M.D.
Gastroenterology

Colonoscopy OsmoPrep™ Patient Packet

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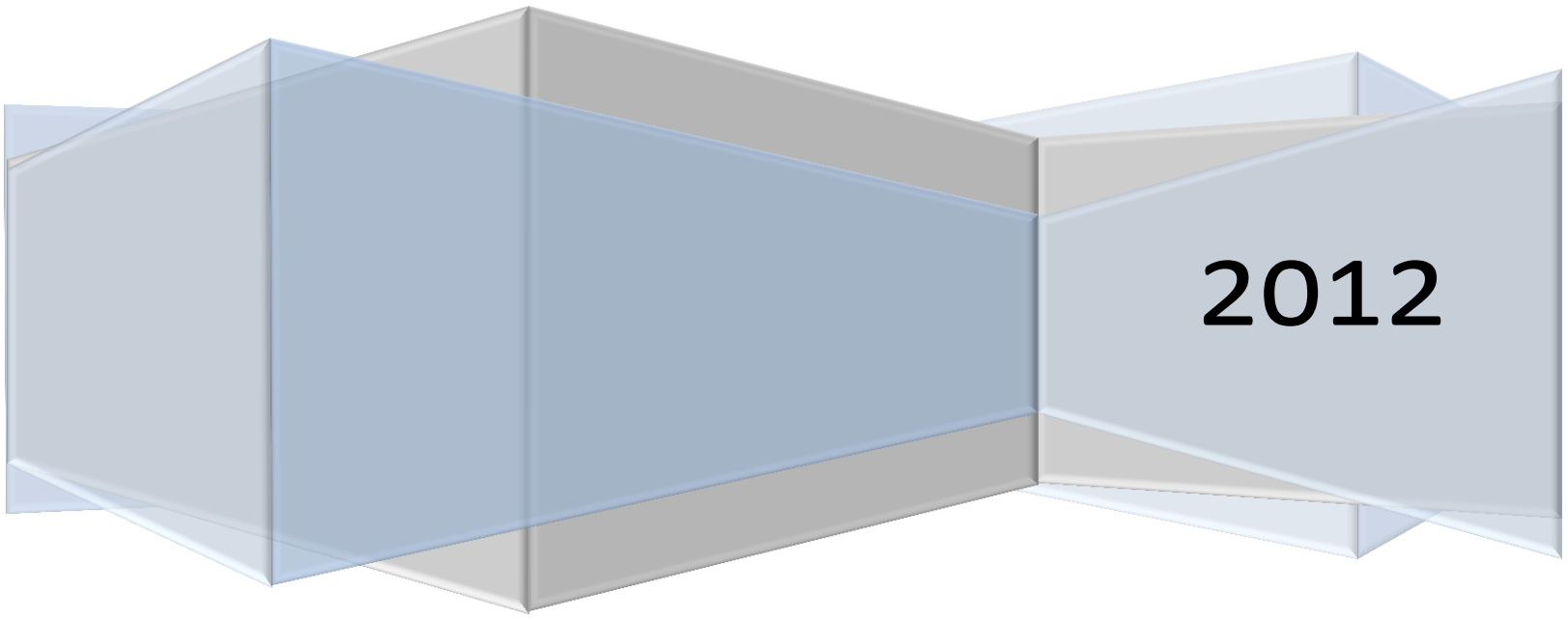

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INSTRUCTIONS FOR COLONOSCOPY: OSMO PREP™ BOWEL PREPARATION

APPOINTMENT DATE: _____ **PROCEDURE TIME**: _____

ARRIVE 45 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.

Information About Colonoscopy:

Colonoscopy is an examination that enables Dr. Kamel to view the lining of the rectum and colon. A colonoscope is a thin flexible tube with a tiny video camera on the end. Complications with Colonoscopy are very uncommon. One possible complication of polyp removal is severe bleeding. A tear in the lining of the colon may occur. Both of these complications require hospitalization and, possibly, surgery. Please discuss possible complications with Dr. Kamel.

Preparing For The Colonoscopy:

Inform Dr. Kamel if you have a history of prosthetic heart valve replacement, endocarditis, or a systemic-pulmonary shunt, since you will require antibiotics prior to your examination. Patients with mitral valve prolapse do not need antibiotics prior to their colonoscopy. Also, inform Dr. Kamel if you have an ICD (implantable cardioverter defibrillator). **Complete the GI Lab Patient Questionnaire and GI Laboratory At-Home Medications List** forms and bring them with you to the GI Lab on the day of your colonoscopy.

Most medications can be continued, but some medications need to be discontinued, or the dose adjusted prior to the colonoscopy. **Talk to Dr. Kamel at least 7 days prior to your colonoscopy if you are on any of the following medications: anticoagulants (blood thinners), insulin or oral diabetes medications. If possible, stop all aspirin products and pain medications for arthritis 7 days prior to your colonoscopy** to minimize the risk of bleeding. On the day of your colonoscopy, take all of your routine medications with sips of water. Tylenol or acetaminophen is perfectly safe to take prior to your colonoscopy.

Clear liquid diet should be taken for ***the entire day before and continued up to* 2 *hours prior* to your colonoscopy:** water, clear soda (7-Up, Sprite, Ginger Ale) and fruit juices, coffee/tea, plain gelatin and popsicles (any color ***but red or purple***), broth or bouillon. **Solid foods, milk, or milk products are not allowed. *Do not eat or drink anything during the* 2 *hours prior to your colonoscopy.***

Taking the prescribed Osmo Prep™ tablets:

First 20 Osmo Prep™ TM Tablets: The **evening before your colonoscopy** 20 of the Osmo Prep™ tablets will be taken over a 1-hour time period. **Starting at 5 p.m. (you can start earlier or later than 5 p.m.), take 4 Osmo Prep™ tablets every 15 minutes with at least 1 glass (8 ounces) of clear liquids (water, any clear carbonated drink or clear juice).** It is very important to drink at least 8 ounces of clear liquid when taking the Osmo Prep™ ™ tablets to prevent excessive fluid loss or dehydration. Do not exceed 20 Osmo Prep™

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tablets. You will begin having bowel movements within 1 to 2 hours after finishing the 20 Osmo Prep™ tablets.

Dose 1	5:00 p.m.	4 tablets with 8 ounces of clear liquids
Dose 2	5:15 p.m.	4 tablets with 8 ounces of clear liquids
Dose 3	5:30 p.m.	4 tablets with 8 ounces of clear liquids
Dose 4	5:45 p.m.	4 tablets with 8 ounces of clear liquids
Dose 5	6:00 p.m.	4 tablets with 8 ounces of clear liquids

Follow-up the last dose of tablets with an additional* 12 *ounces of clear liquids.

Last 12 Osmo Prep™ Tablets: On the **day of your colonoscopy**, the last 12 Osmo Prep™ tablets will be taken over a 30 minute period, 3 to 5 hours before leaving home. **Take 4 Osmo Prep™ tablets every 15 minutes with at least 1 glass (8 ounces) of clear liquids (water, any clear carbonated drink or clear juice).** It is very important to drink at least 8 ounces of clear liquid when taking the Osmo Prep™ tablets to prevent excessive fluid loss or dehydration.

Dose 1 ***(Take* 3 *to* 5 *hours before leaving home)*** ___a.m. 4 tablets with 8 ounces of clear liquids
Dose 2 ***(Take* 15 *minutes after Dose* 1)** ___a.m. 4 tablets with 8 ounces of clear liquids
Dose 3 ***(Take* 15 *minutes after Dose* 2)** ___a.m. 4 tablets with 8 ounces of clear liquids
Follow-up the last dose of tablets with an additional* 12 *ounces of clear liquids.

If you cannot tolerate the Osmo Prep™ tablets, or if you are not passing clear yellow liquid after completing the 32 tablets, call Dr. Kamel's office at 312.573.9626 or his answering service after hours at 312.649.2952 to speak to Dr. Kamel.

During the Colonoscopy:
Dr. Kamel will explain the examination and answer any questions you may have. You will be given pain and sedative medications through an IV to keep you comfortable. The colonoscope will be inserted into your rectum and gently advanced through the colon. The colonoscopy procedure usually lasts 30 to 60 minutes and is usually well tolerated. Any discomfort that takes place usually comes as a bloating feeling when the physician puts air into the colon to expand the folds of the colonic tissue for easier viewing, or a cramping feeling when the colonoscope is advanced around the curves of the large intestine.

After the Colonoscopy:
You will be monitored after the procedure in the recovery area for a minimum of 1 hour. Dr. Kamel will discuss your test results with you and your family. Biopsy results take several days to return and Dr. Kamel will discuss them with you by telephone. You absolutely cannot drive until the next day, and an adult must accompany you home. You cannot take public transportation by yourself. You may do light activity for the remainder of the day. It is important for you to recognize signs and symptoms that should be reported to your physician which are: severe abdominal pain, fevers (above 100.5°), chills or severe rectal bleeding. Some scant bleeding may occur. Please be aware you will receive discharge instructions before leaving the GI Lab. You can speak to Dr. Kamel if you have any questions or concerns after returning home at the office at 312.573.9626 or after hours at 312.649.2952.

Northwestern Memorial® Hospital

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

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?

YES	NO		YES	NO	
☐	☐	Sleeping or Anti Anxiety Medications, Sedatives	☐	☐	Prescribed Anticoagulants, Blood Thinners Last Dose Taken (Date_____Time _____)
☐	☐	Aspirin or Non-steroidal Anti-Inflammatory Drugs	☐	☐	Insulin or pills to control your blood sugar

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

Past/Present History:

YES	NO	
☐	☐	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:** _____

Northwestern Memorial® Hospital

GI LABORATORY
At-Home Medications List

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)

Source	Reaction	Source	Reaction
Example: Penicillin	*Hives*	3.	
1.		4.	
2.		5.	

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

DRUG List the medications you are taking, include all over-the-counter medicines, vitamins, herbals, minerals, and those you may have held for today's visit.	**STRENGTH** List the strength of each tablet, capsule, etc.	**DOSE/ DOSE FORM** How many tablets, units, capsules, are you taking at one time?	**FREQUENCY** How often do you take the medication? (once a day, twice a day, etc.)	**ROUTE** How are you taking this medication? (by mouth,injection, patch, etc.)	**LAST DOSE TAKEN** Indicate the date and time you last took the medication	Physician/Staff Use ***Physician:*** **Please check if prescribing additions or changes to chronic medications** ***Staff:*** **If checked, refer to Instructions below. If not checked, file list**
Ex. Cardizem CD	*180 mg*	*1 capsule*	*once a day*	*by mouth*	*9 pm last night*	☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐

Date:_____

Do not write below this line - Hospital Staff ONLY

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):

Condition Medication is prescribed for:	Take this Medication at this Strength:	At this Dose/Dose Form:	How often: (Frequency)	Route:	Start taking this Medication on:	Date, if any, you should **stop** taking this medication:
					___/____/____	
					___/____/____	

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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