

COLONOSCOPY PREPARATION

Appointment Date: _____ Time: _____

**LOCATION: SOUTHDALÉ MEDICAL CENTER
6545 FRANCE AVE S. SUITE 480
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	+ Hemocult	Y	N
Abnl X-Ray	Y	N	FH colon Ca	Y	N
			Who _____	Age _____	

OTHER MAJOR MEDICAL HISTORY: _____

MEDICATIONS: _____

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 entitled, 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 _____