Gastro-Intestinal Consultants of Manhattan, P.A.

W. Travis Dierenfeldt, M.D. **Robert Starnes, P.A.-C**

Upper GI Endoscopy

Welcome to Gastro-Intestinal Consultants of Manhattan, P.A. Your doctor has recommended that you have a medical procedure called **Upper GI Endoscopy**.

You will find the following items enclosed:

- Patient Registration Form
- Medical History Form
- Information Brochure "What is Upper GI Endoscopy?"
- Upper GI Endoscopy Preparation Instructions

Please complete the enclosed forms prior to your appointment. If you have any questions please call our office at 785-539-0156 or Toll Free 1-866-766-1166.

Our office will call you to schedule your appointment

Please bring your completed forms with you to your procedure. You will also have an opportunity to ask our staff any additional questions at that time. Even though you will receive a call from the hospital where your procedure is being performed, you still need to complete these forms and bring them with you.

Thank You

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What is Upper GI Endoscopy?

Your doctor has recommended that you have a medical procedure called upper GI endoscopy to evaluate or treat your condition. This brochure will help you understand how upper GI endoscopy can benefit you and what you can expect before, during, and after this procedure.

What is Upper GI Endoscopy?

The term "endoscopy" refers to a special technique for looking inside a part of the body. "Upper GI" is the portion of the gastrointestinal tract, the digestive system, that includes the esophagus, the swallowing tube leading to the stomach, which is connected to the duodenum, the beginning of the small intestine. The esophagus carries food from the mouth for digestion in the stomach and duodenum.

Upper GI endoscopy is a procedure performed by a gastroenterologist, a well-trained subspecialist who uses the endoscope to diagnose and, in some cases, treat problems of the upper digestive system.

The endoscope is a long, thin, flexible tube with a tiny video camera and light on the end. By adjusting the various controls on the endoscope, the gastroenterologist can safely guide the instrument to carefully examine the inside lining of the upper digestive system.

The high quality picture from the endoscope is shown on a TV monitor; it gives a clear, detailed view. In many cases, upper GI endoscopy is a more precise examination than X-ray studies.

Upper GI endoscopy can be helpful in the evaluation or diagnosis of various problems, including difficult or painful swallowing, pain in the stomach or abdomen, and bleeding, ulcers, and tumors.

How Do I Prepare for the Procedure?

Regardless of the reason upper GI endoscopy has been recommended for you, there are important steps you can take to prepare for and participate in the procedure. First, be sure to give your doctor a complete list of all the medicines you are taking and any allergies you have to drugs or other substances.

Your medical team will also want to know if you have heart, lung, or other medical conditions that may need special attention before, during, or after upper GI endoscopy. You will be given instructions in advance that will outline what you should and should not do in preparation for the upper GI endoscopy. Be sure to read and follow these instructions.

One very important step in preparing for upper GI endoscopy is that you should not eat or drink within eight to ten hours of your procedure. Food in the stomach will block the view through the endoscope, and it could cause vomiting.

Upper GI endoscopy can be done in either a hospital or outpatient office. You'll be asked to sign a form that verifies that you consent to having the procedure and that you understand what is involved.

If there is anything you don't understand, ask for more information!

What Can You Expect During an Upper GI Endoscopy?

During the procedure, everything will be done to help you be as comfortable as possible. Your blood pressure, pulse, and the oxygen level in your blood will be carefully monitored. Your doctor may give you a sedative medication; the drug will make you relaxed and drowsy, but you will remain awake enough to cooperate.

You may also have your throat sprayed or be asked to gargle with a local anesthetic to help keep you comfortable as the endoscope is passed. A supportive mouthpiece will be placed to help you keep your mouth open during the endoscopy. Once you are fully prepared, your doctor will gently maneuver the endoscope into position.

As the endoscope is slowly and carefully inserted, air is introduced through it to help your doctor see better. During the procedure, you should feel no pain and it will not interfere with your breathing.

Your doctor will use the endoscope to look closely for any problems that may require evaluation, diagnosis, or treatment.

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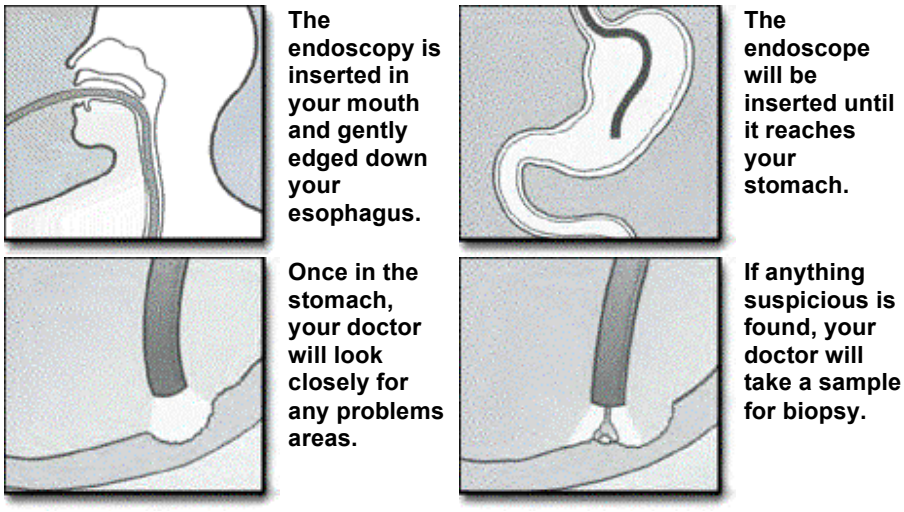
In some cases, it may be necessary to take a sample of tissue, called a biopsy, for later examination under the microscope. This, too, is a painless procedure. In other cases, this endoscope can be used to treat a problem such as active bleeding from an ulcer.

What are the Possible Complications From an Upper GI Endoscopy?
Years of experience have proved that upper GI endoscopy is a safe procedure. Typically, it takes only 15-20 minutes to perform.
Complications rarely occur. These include perforation - a puncture of the esophagus, stomach or intestinal wall, which could require surgical repair, and bleeding, which could require transfusion. Again, these complications are unlikely. Be sure to discuss any specific concerns you may have with your doctor.
When your endoscopy is completed you'll be cared for in a recovery area until most of the effects of the medication have worn off.
Your doctor will inform you about the results of the procedure and provide any additional information you need to know.

What Can I Expect After My Upper GI Endoscopy?
You will be given instructions regarding how soon you can eat and drink, plus other guidelines for resuming your normal activity.
Occasionally, minor problems may persist, such as mild sore throat, bloating, or cramping; these should disappear in 24 hours or less.
By the time you're ready to go home, you'll feel stronger and more alert. Nevertheless, you should plan on resting for the remainder of the day. This means not driving, so you'll need to have a family member or friend take you home.
In a few days, you will hear from your doctor with additional information such as results of the biopsy, or you may have questions you want to ask the doctor directly.

How Endoscopy Works



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Instructions for Upper GI Endoscopy

Date of Procedure_____

Time to Arrive at Facility_____

Time of Procedure_____

Location of Procedure:

Mercy Regional Health Center at College
1823 College Avenue
Manhattan, KS 66502
785-776-3322

Manhattan Surgical Hospital
1829 College Avenue
Manhattan, KS 66502
785-776-5100

If you need to cancel or reschedule for any reason, please notify us at least 24-48 hours in advance.

1. Please arrive promptly for your appointment. We ask that you arrive one hour prior to your scheduled procedure time. This allows time for registration and the nurse to start an IV. Late arrivals may necessitate cancellation of your appointment.
2. Please take your medications with small sips of water on the day of your procedure.
3. Please bring a list of all your medications with you to your procedure.
4. Please notify my office if you take Coumadin, Plavix, Aspirin, blood thinners or insulin so that we can discuss dosing prior to your procedure.
5. Because you will be sedated, please bring a responsible person with you to your appointment who can talk with me about your examination and any instructions for medications or further tests. This person must also drive you home after your test.

The Day Before Your Examination

You may eat a regular diet.

Do not eat or drink anything after midnight the night before your test unless your test is scheduled in the afternoon.

The Day of Your Examination

If Your Procedure is Scheduled Before Noon: You may take your morning medications with sips of water. Do not eat or drink anything else.

If Your Procedure is Scheduled After Noon: You may take your morning medications with sips of water. You may have a clear liquid breakfast. Do not eat or drink anything after 8:00 A.M.

Please call if you have any questions or concerns about your procedure.

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(Please review and sign if your procedure is scheduled at Manhattan Surgical Hospital)

Disclosure of Ownership

The Manhattan Surgical Hospital, LLC is owned by a Limited Liability Corporation, which is partly owned by local physicians. Dr. Dierenfeldt is an owner of the company as a result of his commitment to quality health care and service to his patients.

You have the right to choose to receive your medical services from a different site and from a health care provider other than Manhattan Surgical Hospital. Please contact Dr. Dierenfeldt if you wish to obtain information on any such alternative sites for services in this area.

By your signature below, you acknowledge receiving the information explained in this Disclosure of Ownership.

Patient Signature

_____Date_____

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Gastro-Intestinal Consultants of Manhattan, P.A.

Medical History Form

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Robert J. Starnes, P.A.-C

Date / /
Name_____ Date of Birth _____ Age_____

Primary care physician's name_____ Pharmacy and location _____

What is the main reason for your visit today? _____

Medical History (check all that apply)
Have you had or been diagnosed with any of the following gastro-intestinal conditions?

☐ Esophageal Reflux	☐ Hiatal hernia	☐ Chronic Diarrhea	☐ Fatty Liver
☐ Barrett's Esophagus	☐ Colon Polyps	☐ Chronic Constipation	☐ Autoimmune Hep
☐ Esophageal Stricture (narrowing)	☐ Colon Cancer	☐ Gallstones	☐ PBC
☐ Esophageal Varices	☐ Crohn's Disease	☐ Pancreatitis	☐ PSC
☐ Gastritis	☐ Ulcerative Colitis	☐ Pancreatic Cancer	☐ Cirrhosis of Liver
☐ Helicobacter Pylori Infection	☐ Irritable Bowel Syndrome		☐ Hepatitis A
☐ Stomach Ulcer	☐ Diverticulosis		☐ Hepatitis B
☐ Duodenal Ulcer	☐ Diverticulitis		☐ Hepatitis C

Have you had or been diagnosed with any of the following other conditions?

☐ High blood pressure	☐ Anemia, iron deficiency	☐ Emphysema	☐ Blood Transfusion
☐Heart Murmur	☐ Anemia, blood loss	☐ Asthma	☐Other _____
☐Heart Disease	☐ Anemia, unspecified	☐ Breast Cancer	☐Other _____
☐High Cholesterol	☐ Diabetes	☐ Uterine Cancer	☐ Other _____
☐ Artificial Heart Valve	☐ Thyroid disorder	☐ Prostate Cancer	
Please list any other medical problems you have had in the past.		☐ Radiation Treatment	

Surgery History (check all that apply)

	Year		Year		Year
☐ Gallbladder Removal		☐ Tonsillectomy		☐ Joint Replacement	
☐ Appendix Removal		☐ Tubal Ligation		☐ Mastectomy	
☐ Gastric bypass		☐ Hysterectomy		☐ Upper endoscopy	
☐ Colon Resection		☐ Heart Bypass		☐ Colonoscopy	
☐ Hernia Repair		☐ Vascular Surgery		☐ Other	
☐ Nissen Fundoplication					

Current Medications (medications you are taking or have taken in the last 2 months)

Do you take: ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Ibuprofen ☐ Naproxen/Aleve ☐ Other NSAID

If yes, how often? _____

Name of Medication	Dose	Name of Medication	Dose

Are you allergic to any medications? ☐ YES ☐ No If YES, list medications and type of reaction you had?

Name of Medication	Reaction	Name of Medication	Reaction

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Family History ☐ Adopted

List diseases of your Mother, Father, Sister, or Brother Mother=M Father=F Sister=S Brother=B

	M	F	S	B		M	F	S	B		M	F	S	B
☐ Colon Polyps					☐ Crohn's Disease					☐ Gallbladder disease				
☐ Colon Cancer					☐ Pancreatitis					☐ Stomach Ulcer				
☐ Irritable Bowel Syndrome					☐ Liver Disease					☐ Duodenal Ulcer				
☐ Ulcerative Colitis					☐ Hepatitis					☐ Other GI Diseases				

Social History

What is your occupation? _____

Do you drink alcohol?	☐ Currently	☐ In Past	☐ Never
Do you Smoke?	☐ Currently	☐ In Past	☐ Never
Have you ever used intravenous drugs?	☐ Currently	☐ In Past	☐ Never

Review of Systems (check all that apply)

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Weakness
- ☐ Fatigue

Ears,Eyes,Nose,Throat
- ☐ Decreased hearing
- ☐ Ear pain
- ☐ Nasal congestion
- ☐ Sore throat

Respiratory
- ☐ Short of breath
- ☐ Cough
- ☐ Sputum production
- ☐ Blood in sputum
- ☐ Wheezing

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations
- ☐ Slow heart
- ☐ Fast heart
- ☐ Edema
- ☐ Passing out

Gastrointestinal
- ☐ Nausea
- ☐ Vomitting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Heartburn
- ☐ Blood in vomit
- ☐ Abdominal pain

Urinary
- ☐ Painful urination
- ☐ Blood in urine

Heme/Lymph
- ☐ Bruise easily
- ☐ Bleed easily
- ☐ Swollen lymph glands

Endocrine
- ☐ Excessive thirst
- ☐ Frequent urination
- ☐ Cold intolerance
- ☐ Heat intolerance

Musculoskeletal
- ☐ Back pain
- ☐ Neck pain
- ☐ Joint pain
- ☐ Muscle pain

Skin
- ☐ Rash
- ☐ Itching
- ☐ Abrasions

Neurologic
- ☐ Confusion
- ☐ Numbness
- ☐ Tingling
- ☐ Headache

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Mania
- ☐ Delusional
- ☐ Hallucinations

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Patient Registration Form

*****Personal Information*****

Last Name	First Name		Middle Name
Home Address	City	State	Zip Code
Phone ☐Home ☐Cell	Date of Birth	Social Security Number	
Your Occupation	Email		
Employer		Business Phone	
Employer Address	City	State	Zip Code
Marital Status ☐Married ☐Single ☐ Widowed ☐Divorced ☐ Separated			
Gender ☐Male ☐ Female	Race/Ethnicity	Preferred Language	

*****Contact Information*****

Name of Spouse or Nearest Relative			Relationship
Address	City	State	Zip Code
Home Telephone		Social Security Number	
Employer		Business Phone	

*****Physician Information*****

Referring Physician
Primary Care Physician

*****Responsible Party if other than Patient*****

Last Name	First Name		Middle Name
Address	City	State	Zip Code
Telephone			
Employer		Business Phone	
Employer Address	City	State	Zip Code

*****Insurance Information*****

Insurance Company Name	Identification Number	Subscriber's Name
Primary Insurance Name	Identification # Group Name and #	Subscriber's Name Date of Birth
	Your relationship to subscriber ☐Self ☐Spouse ☐Child ☐ Other	
Secondary Insurance Name	Identification # Group Name and #	Subscriber's Name Date of Birth
	Your relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐Other	

*****Authorization to Release Information and Assignment of Insurance Benefits*****

I hereby authorize this medical practice to release to my insurance company(s) all information that said party(s) may request concerning my illness or injury. I hereby assign to this medical practice all monies to which I am entitled for the medical expenses relative to the services reported but not to exceed my indebtedness to this medical practice. I understand I am financially responsible to this medical practice for all charges personally incurred here and agree to be personally and fully responsible for payment of this account. I also authorize the exchange of medical records and/or information concerning my condition with other physicians, allied health providers, or medical facilities as determined by the clinical staff of this medical practice to be in the best interest of my medical treatment. A photocopy of this authorization shall be considered as effective and valid as the original.

Patient Signature	Today's Date
Signature of Responsible Party	☐ Parent ☐ Guardian

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