Gastro-Intestinal Consultants of Manhattan, P.A.

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

Colonoscopy with MiraLAX Prep

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

You will find the following items enclosed:

- Information Brochure "What is Colonoscopy?"
- Patient Information Brochure
- Colonoscopy Preparation Instructions
- Medical History Form
- Patient Registration Form

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. In addition, we have a brief video about a colonoscopy on our website at www.giofmanhattan.com

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

1213 Hylton Heights Road • Suite 101 • Manhattan, Kansas 66502
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What is Colonoscopy?
Your doctor has recommended that you have a medical procedure called a colonoscopy to evaluate or treat your condition. This brochure will help you understand how a colonoscopy can benefit you and what you can expect before, during, and after this procedure.

What is a Colonoscopy?
The term "colonoscopy" means looking inside the colon. It is a procedure performed by a gastroenterologist, a well-trained subspecialist.
The colon, or large bowel, is the last portion of your digestive or GI tract. It starts at the cecum, which attaches to the end of the small intestine, and it ends at the rectum and anus. The colon is a hollow tube, about five feet long, and its main function is to store unabsorbed food products prior to their elimination.
The main instrument that is used to look inside the colon is the colonoscope, which is a long, thin, flexible tube with a tiny video camera and a light on the end. By adjusting the various controls on the colonoscope, the gastroenterologist can carefully guide the instrument in any direction to look at the inside of the colon. The high quality picture from the colonoscope is shown on a TV monitor, and gives a clear, detailed view. Colonoscopy is more precise than an X-ray. This procedure also allows other instruments to be passed through the colonoscope. These may be used, for example, to painlessly remove a suspicious-looking growth or to take a biopsy-a small piece for further analysis. In this way, colonoscopy may help to avoid surgery or to better define what type of surgery may need to be done.
A shorter version of the colonoscope is called a sigmoidoscope, an instrument used to screen the lower part of the large bowel only. The colonoscope, however, is long enough to inspect all of the large bowel and even part of the small intestine.
Colonoscopy is a safe and effective way to evaluate problems such as blood loss, pain, and changes in bowel habits such as chronic diarrhea or abnormalities that may have first been detected by other tests. Colonoscopy can also identify and treat active bleeding from the bowel.
Colonoscopy is also an important way to check for colon cancer and to treat colon polyps - abnormal growths on the inside lining of the intestine. Polyps vary in size and shape and, while most are not cancerous, some may turn into cancer. However, it is not possible to tell just by looking at a polyp if it is malignant or potentially malignant. This is why colonoscopy is often used to remove polyps, a technique called a polypectomy.

How Do I Prepare for the Procedure?
There are important steps that you must take to prepare for the procedure. First, be prepared to give a complete list of all the medicines you are taking, as well as any allergies you have to drugs or other substances. Your medical team will also want to know if you have any other medical conditions that may need special attention before, during, or after the colonoscopy.
You will be given instructions in advance that will outline what you should and should not do in preparation for colonoscopy. **Be sure to read and follow these instructions.** One very critical step is to thoroughly clean out the colon, which, for many patients, can be the most trying part of the entire exam. It is essential that you complete this step carefully, because how well the bowel is emptied determines the success of the procedure. Be sure to follow instructions as directed.
You'll be asked to sign a form that gives your consent to the procedure and states that you understand what is involved. If there is anything you don't understand, ask for more information.

What Can You Expect During a Colonoscopy?
During the procedure, everything will be done to ensure your comfort. An intravenous, or IV, line will be inserted to give you medication to make you relaxed and drowsy. The drug will enable you to remain awake and cooperative, but it may prevent you from remembering much of the experience.
Once you are fully relaxed, your doctor will do a rectal exam with a gloved, lubricated finger; then the lubricated colonoscope will be gently inserted.

As the scope is slowly and carefully passed, you may feel as if you need to move your bowels, and because air is introduced to help advance the scope, you may feel some cramping or fullness. Generally, however, there is little or no discomfort.

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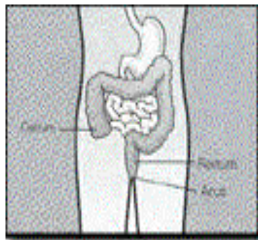
What are the Possible Complications from a Colonoscopy?
Although colonoscopy is a safe procedure, complications can sometimes occur. These include perforation - a puncture of the colon walls, which could require surgical repair.
When polyp removal or biopsy is performed, hemorrhage (heavy bleeding) may result and sometimes require blood transfusion or reinsertion of the colonoscope to control the bleeding. Be sure to discuss any specific concerns you may have about the procedure with your doctor.
The time needed for colonoscopy will vary, but on the average, the procedure takes about 30 minutes. Afterwards, you'll be cared for in a recovery area until the effects of the medication have worn off. At this time, your doctor will inform you about the results of your colonoscopy and provide any additional information that you need to know. You'll also be given instructions about how soon you can eat and drink, plus other guidelines for resuming your normal routine.

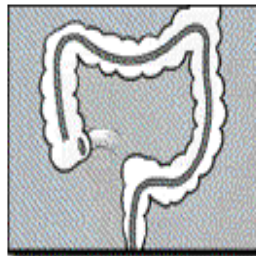
What Can You Expect After Your Colonoscopy?
Occasionally, minor problems may persist, such as bloating, gas, or mild cramping. These symptoms should disappear in 24 hours or less. By the time you're ready to go home, you'll feel stronger and more alert. Nevertheless, rest for the remainder of the day. Have a family member or friend take you home.
A day or so after you're home, you might speak with a member of the colonoscopy team for follow-up, or you may have questions you want to ask the doctor directly.

Colonoscopy is an effective technique for evaluating and, in many cases, improving your digestive health.

How Colonoscopy Works.

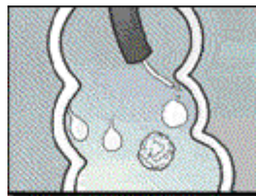


The colonoscope is inserted in your anus and gently guided to the cecum, the first part of your digestive tract.



Upon reaching the colon, your doctor can guide the colonoscope to view the entire area.

Upon finding something suspicious, your doctor can take a biopsy.



….or do a polypectomy.

7/2009

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MiraLAX Preparation Instructions for Colonoscopy

Date of Procedure_______________

Time to Arrive at Hospital_________

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. You must purchase :
    a.) One **bottle of MiraLAX** (238 gm)—this is available over the counter at drug store
    b.) Four **Dulcolax tablets**—available over the counter at the drug store
    c.) One 64 Ounce Bottle of **Gatorade (pick a flavor that is not red in color)**
2. 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.
3. Please take your medications with small sips of water on the day of your procedure.
4. Please bring a list of all your medications with you to your procedure.
5. Please notify my office in advance if you take Coumadin, Plavix, blood thinners or insulin so that we can discuss dosing prior to your procedure.
6. Because you will be sedated, please bring a responsible person with you to your appointment so they 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 breakfast.

After 9:00 A.M. the day before your procedure you may have clear liquids only. The following are considered clear liquids: apple, grape, and cranberry juices; broth; coffee; Gatorade; hard candy; Jell-O; Koolaid; popsicles; soda pop; and tea. Do not have anything red colored.

To prevent soreness, you may want to apply Preparation H, Desitin, or Vaseline to the anus before beginning the prep and as needed.

At 3:00 P.M. take 4 Dulcolax tablets with 8 ounces of clear liquid.

At 6:00 P.M. mix one 64 ounce bottle of Gatorade with bottle of MiraLAX (238 grams). Drink one 8 ounce glass every 15 minutes until gone. This will take about two hours. If you become nauseated, drink it slower. You may have clear liquids again until midnight.

The Day of Your Examination

IF Your Procedure is Scheduled Before Noon

Please take your morning medications with sips of water.

Do not eat or drink anything else after taking your morning medications.

IF Your Procedure is Scheduled After Noon

Please take your morning medications with sips of water.

You may drink clear liquids up to 8:00 AM on the day of your procedure. Do not drink anything after 8:00 AM.

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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Medical History Form

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

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

☐ High blood pressure
☐ Heart Murmur
☐ Heart Disease
☐ High Cholesterol
☐ Artificial Heart Valve
☐ Anemia, iron deficiency
☐ Anemia, blood loss
☐ Anemia, unspecified
☐ Diabetes
☐ Thyroid disorder
☐ Emphysema
☐ Asthma
☐ Breast Cancer
☐ Uterine Cancer
☐ Prostate Cancer
☐ Radiation Treatment
☐ Blood Transfusion
☐ Other ____________
☐ Other ____________
☐ Other ____________

Please list any other medical problems you have had in the past.

____

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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