

# **Gastro-Intestinal Consultants of Manhattan, P.A.**

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**W. Travis Dierenfeldt, M.D.**

**Robert Starnes, P.A.-C**

## **Colonoscopy with OSMOPREP 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](http://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

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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.

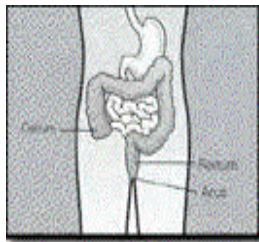
The time needed for colonoscopy will vary, but on the average, the procedure takes about 30 minutes. Afterwards, you'll be cared for in a recovery area until the effects of the medication have worn off. At this time, your doctor will inform you about the results of your colonoscopy and provide any additional 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.



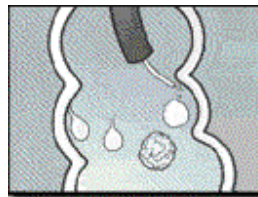
The colonoscope is inserted in your anus and gently guided to the cecum, the first part of your digestive tract.



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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## **OSMO 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 **obtain a prescription** and purchase **32 OsmoPrep tablets** from the drug store .
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 if you take Coumadin, Plavix, Aspirin, 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 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** 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 any artificial 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 5:00 P.M.** take **4 tablets OsmoPrep tablets with 8 ounces of clear liquid**. Repeat every 15 minutes for a total of 20 tablets. Drink plenty of liquids during this process.

You may drink clear liquids the rest of the night.

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## **The Day of Your Examination**

### **IF Your Procedure is Scheduled Before Noon**

At 5:00 A.M. take **4 OsmoPrep tablets with 8 ounces of Gingerale or 7-up.** Repeat in 15 minutes for a total of 12 tablets.

Please take your morning medications with sips of water after you take the OsmoPrep.

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

### **IF Your Procedure is Scheduled After Noon**

At 7:00 A.M. take **4 tablets of OsmoPrep with 8 ounces of Gingerale or 7-up.** Repeat in 15 minutes for a total of 12 tablets.

Please take your morning medications with sips of water after you take the OsmoPrep.

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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# Gastro-Intestinal Consultants of Manhattan, P.A.

## 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?

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

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

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> High blood pressure                     | <input type="checkbox"/> Anemia, iron deficiency | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Heart Murmur                            | <input type="checkbox"/> Anemia, blood loss      | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Other _____       |
| <input type="checkbox"/> Heart Disease                           | <input type="checkbox"/> Anemia, unspecified     | <input type="checkbox"/> Breast Cancer       | <input type="checkbox"/> Other _____       |
| <input type="checkbox"/> High Cholesterol                        | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Uterine Cancer      | <input type="checkbox"/> Other _____       |
| <input type="checkbox"/> Artificial Heart Valve                  | <input type="checkbox"/> Thyroid disorder        | <input type="checkbox"/> Prostate Cancer     |  |
| Please list any other medical problems you have had in the past. |  | <input type="checkbox"/> Radiation Treatment |  |

### Surgery History

(check all that apply)

- |  | Year  |   | Year  |  | Year  |
|--|-------|---|-------|--|-------|
| <input type="checkbox"/> Gallbladder Removal   | _____ | <input type="checkbox"/> Tonsillectomy    | _____ | <input type="checkbox"/> Joint Replacement | _____ |
| <input type="checkbox"/> Appendix Removal      | _____ | <input type="checkbox"/> Tubal Ligation   | _____ | <input type="checkbox"/> Mastectomy        | _____ |
| <input type="checkbox"/> Gastric bypass        | _____ | <input type="checkbox"/> Hysterectomy     | _____ | <input type="checkbox"/> Upper endoscopy   | _____ |
| <input type="checkbox"/> Colon Resection       | _____ | <input type="checkbox"/> Heart Bypass     | _____ | <input type="checkbox"/> Colonoscopy       | _____ |
| <input type="checkbox"/> Hernia Repair         | _____ | <input type="checkbox"/> Vascular Surgery | _____ | <input type="checkbox"/> Other             | _____ |
| <input type="checkbox"/> 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
<input type="checkbox"/> Colon Polyps					<input type="checkbox"/> Crohn's Disease				
<input type="checkbox"/> Colon Cancer					<input type="checkbox"/> Pancreatitis				
<input type="checkbox"/> Irritable Bowel Syndrome					<input type="checkbox"/> Liver Disease				
<input type="checkbox"/> Ulcerative Colitis					<input type="checkbox"/> Hepatitis				
					<input type="checkbox"/> Gallbladder disease				
					<input type="checkbox"/> Stomach Ulcer				
					<input type="checkbox"/> Duodenal Ulcer				
					<input type="checkbox"/> 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
- Vomiting
- 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 <input type="checkbox"/> Home <input type="checkbox"/> Cell		Date of Birth	Social Security Number	
Your Occupation		Email		
Employer			Business Phone	
Employer Address		City	State	Zip Code
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated				
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Race/Ethnicity		Preferred Language	

### \*\*\*Contact Information\*\*\*

Name of Spouse or Nearest Relative			Relationship
Address		City	State
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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Secondary Insurance Name	Identification #                      Group Name and #	Subscriber's Name                      Date of Birth
	Your relationship to subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian