

***SOUTH SUBURBAN GASTROENTEROLOGY, PC
WEYMOUTH ENDOSCOPY, LLC***

1085 MAIN STREET ~ SOUTH WEYMOUTH, MA 02190
TEL: 781-331-2922 FAX: 781-335-5702
WEB SITE: WWW.SSUBGASTRO.COM

Dear Patient,

This packet is being mailed to you, per recommendation from your current or previous Gastroenterologist, that you are due for a follow up colonoscopy and/ or endoscopy procedure.

Thank you for choosing South Suburban Gastroenterology/ Weymouth Endoscopy for your procedure. Enclosed are the forms required in order to schedule your procedure. Please complete the packet and return it to our office. **Once we have received your completed forms we will schedule your procedure.**

Once you are scheduled for your procedure, we will mail out your assigned date & time along with your prep instructions. Please review the instructions at least one week prior to your procedure. You may purchase your prep at your local pharmacy.

If you have any questions please call us at 781-331-2922 or visit our web site at www.ssubgastro.com. We look forward to providing you with the highest quality of care.

Sincerely,

The Physicians of South Suburban Gastroenterology

Dr. Gregory Bolduc
Dr. Thomas Kenney
Dr. Christopher Kenney
Dr. Brian Gill
Dr. Jonathan Nass
Dr. Arslan Talat

***Please return this packet by mail: 1085 Main Street. S. Weymouth, Ma 02190
fax: 781-335-5702 or
email: mary@weymouthendoscopy.com***

PATIENT HISTORY FORM REVIEW OF SYSTEMS

Name: _____

Date of Birth: _____

Constitutional

Recent Weight Change ___ YES ___ NO
Fever ___ YES ___ NO
Fatigue ___ YES ___ NO

Eyes

Blurred Vision ___ YES ___ NO
Glaucoma ___ YES ___ NO

Ears/Nose/Mouth/Throat

Hearing Loss ___ YES ___ NO
Ringing in Ears ___ YES ___ NO
Mouth Sores ___ YES ___ NO

Cardiovascular

Chest Pain ___ YES ___ NO
Shortness of Breath ___ YES ___ NO
Swelling of Ankles ___ YES ___ NO

Respiratory

Chronic Cough ___ YES ___ NO
Spitting up Blood ___ YES ___ NO
Wheezing ___ YES ___ NO

Genitourinary

Burning with Urination ___ YES ___ NO
Blood in Urine ___ YES ___ NO

Musculoskeletal

Joint Pain ___ YES ___ NO
Swelling ___ YES ___ NO
Back Pain ___ YES ___ NO
Muscle Pain ___ YES ___ NO

Skin

Rash ___ YES ___ NO
Itching ___ YES ___ NO

Gastrointestinal

Poor Appetite ___ YES ___ NO
Difficulty in Swallowing ___ YES ___ NO
Heartburn ___ YES ___ NO
Nausea ___ YES ___ NO
Vomiting ___ YES ___ NO
Bloating ___ YES ___ NO
Belching ___ YES ___ NO
Regurgitation ___ YES ___ NO
Constipation ___ YES ___ NO
Diarrhea ___ YES ___ NO
Abdominal Pain ___ YES ___ NO
Recent Change in Bowel Habits ___ YES ___ NO
Rectal Bleeding ___ YES ___ NO
Black, Tarry Stools ___ YES ___ NO

Neurological

Headaches ___ YES ___ NO
Seizures ___ YES ___ NO
Numbness ___ YES ___ NO
Strokes ___ YES ___ NO

Psychiatric

Memory Loss or Confusion ___ YES ___ NO
Depression ___ YES ___ NO

Endocrine

Heat Intolerance ___ YES ___ NO
Cold Intolerance ___ YES ___ NO
Excessive Thirst ___ YES ___ NO
Excessive Urination ___ YES ___ NO

Hematological

Bleeding Tendency ___ YES ___ NO
Bruising Tendency ___ YES ___ NO
Anemia ___ YES ___ NO
Past Transfusion ___ YES ___ NO
Are you Pregnant? ___ YES ___ NO

* Height _____ *Weight _____

Do you take any blood thinners? No Yes What Medication _____

If yes who is the prescribing doctor? _____

Medication Allergies: _____

List of Medications and Doses: _____

Name _____ Date of Birth _____
 Language: _____ Height: _____ Weight: _____ ** BMI _____ **
 Primary Care Physician: _____ Pharmacy: _____ Location: _____
 Reason for today's visit: _____
List all prior surgeries and date: _____

Circle Present and Past Medical History:

Hypertension Heart Attack Angina Arrhythmia Congestive Heart Failure Heart Murmur Elevated Cholesterol
 Diabetes Anemia Arthritis Blood Clot in Leg or Lung Seizure Stroke Hepatitis Tuberculosis Cancer
 Asthma Bronchitis Emphysema Rheumatic Fever Thyroid Disease Peptic Ulcer Hiatal Hernia Ulcerative
 Colitis Crohn's Disease Irritable Bowel Syndrome Sleep Apnea Anxiety/Depression Reflux Constipation
 Other: _____

Have you ever had a colonoscopy before?
 No Yes
 If so, when and where? _____

Have you ever smoked? No Yes
 If currently smoking, how many packs per day? _____
 If not currently smoking, quit date: _____

Have you ever had any problems with anesthesia
 or sedation? No Yes
 If yes, what happened? _____

Do you drink alcohol? None Occasional Daily
 Recreational drug use? No Yes
 Marital Status: Single Married Divorced Widowed
 Do you work? No Yes Type of Work: _____

Any family history of liver disease, celiac disease, Crohn's, ulcerative colitis, other cancer? _____
 Colon Polyps: No Yes Whom: _____
 Colon Cancer: No Yes Whom: _____
 Other Significant Disease(s): _____

To Be Completed by Gastroenterologist on day of exam:

HPI: _____

Physical Examination:	BP _____	Hgt _____	Wgt _____	Yes	No	Comments
1. Constitutional: Well-nourished/well developed:				<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Skin: Skin free of rashes, purpura, petechiae, stigmata:				<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Eyes: Lids and Conjunctivae normal:				<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Ears/Nose/Mouth/Throat: Is the oral mucosa pink/moist				<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Hematologic/Lymphatic/Immunologic: Nodes in neck nl:				<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Respiratory: Lungs clear to auscultation:				<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Cardiovascular: Heart rate regular & no murmur:				<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Gastrointestinal: Soft, nl tympany, active bs, no hsm no masses, no tenderness				<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Musculoskeletal: No clubbing, deformities, edema of extremities				<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Rectal: Hem occult negative:				<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Neurologic: Intact				<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Psychiatric: Alert, oriented to time/person/place				<input type="checkbox"/>	<input type="checkbox"/>	_____

Reviewed By _____ Date: _____

ASA: _____

I have reassessed the patient and find no changes to the above

Reviewed By _____ Date: _____

Name: _____ Date of Birth: _____

Date of Exam: _____

Allergies / Sensitivities and Reactions:

Name of Medication/Vitamin/OTC	Dose	How often taken	Last dose taken
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Physician Documentation:

Any changes to medication after procedure: No Yes _____

New medication added today: No Yes _____

	N/A	Yes	Number of Days
Hold Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hold Ibuprofen, Aleve, Excedrin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hold Blood Thinners	<input type="checkbox"/>	<input type="checkbox"/>	_____

Due to your endoscopic intervention, please refrain from Aspirin and NSAID products for _____ days

MD signature: _____ Date: _____

Nursing Documentation: Today you had the following procedure:

Colonoscopy _____ Gastroscopy _____ Flexible Sigmoidoscopy _____

You were given the following medications: Propofol __ Fentanyl__ Versed __ Zofran __ Lidocaine __ Glycopyrrolate __ Other _____

Endoclip was used today Yes - If yes and you require an MRI in the next month, please notify the Radiologist.

Nurse Signature: _____ Date: _____

WEYMOUTH ENDOSCOPY, LLC.

CONSENT FOR COLONOSCOPY

My physician has recommended a Colonoscopy to evaluate the following condition:

1. **CONDITION**

My physician has explained to me the technique of Colonoscopy, the risks and benefits of Colonoscopy, additional procedures, which may be performed during Colonoscopy and the way in which I will be sedated for my Colonoscopy. I have had an opportunity to ask any questions, discuss alternative therapies, risk and benefits and I have received appropriate responses to these questions.

2. **PROCEDURE: DESCRIPTION OF COLONOSCOPY**

Colonoscopy is an examination of the Colon, using a flexible scope, which will be inserted into the rectum and advanced under visual guidance throughout the entire length of the colon to its junction with the small intestine into the cecum and sometimes into the small intestine. During Colonoscopy, an image of the inside lining of the colon is portrayed on a video monitor and reviewed by my physician. This technique allows the physician a detailed examination of the lining of the bowel where pathology is most likely to occur. This technique has the ability to diagnose most of the common diseases of the colon and to exclude those diagnoses, which are of the greatest concern. Any tissue removed during Colonoscopy will be sent to a pathology laboratory where a Pathologist will review it. A colonoscopy is an imperfect exam and there is a small but real possibility that significant pathology including polyps and small cancers may be missed.

ADDITIONAL PROCEDURES:

Additional procedures are commonly performed during Colonoscopy, which include biopsies of the lining of the large bowel, Polypectomy, which is the removal of polyps and cautery of abnormal blood vessels. Sometimes dilation of stricture or tattoo of lesion site is required. These procedures are performed routinely in Colonoscopy if the appropriate pathology is identified during that examination.

3. **RISKS AND BENEFITS**

RISKS OF COLONOSCOPY:

The risks of Colonoscopy are rare, but may be serious and life threatening. These risks include perforation of the colon by the colonoscope, which usually requires surgical repair. It is possible that a Colostomy may need to be performed during the repair of a perforation. Additional risks include bleeding, which is most likely to occur after removal of a polyp. Bleeding is usually self-limited, but may be serious and can possibly require transfusions and/or surgery to control. Infections, leakage of air from the bowel into the abdominal cavity are also possible complications. Additional risks associated with any invasive procedure, but not specifically associated with Colonoscopy include unanticipated bleeding, development of blood clots, tissue damage, respiratory problems, infections, and cardiovascular or pulmonary complications. There is a risk of infection transmission related to entering a medical facility and undergoing a medical procedure during the current pandemic. **I understand that do not resuscitate directives will not be honored at this facility.**

SEDATION:

During Colonoscopy I will receive intravenous medicine for sedation. This technique may use several different medications alone or in combination, which result in the induction of a sleep like state, during which memory is often impaired. The degree of sedation varies from person to person and it is conceivable that some pain may be felt during the procedure or some discomfort remembered after the procedure. My physician is limited in the amount of medicine that can be administered by safety factors and changes in my vital signs. Complications from sedation include: Inadequate Respiration, which may require respiratory assistance or reversal of the sedative, low blood pressure, erratic or slow pulse rate, all of which may require administration of additional medications.

4. **ACKNOWLEDGEMENT**

I understand the need for Colonoscopy. I understand the potential benefit of the procedure and the potential risks associated with it.

5. **CONSENT**

I give my consent to have the procedure performed by Dr. _____.

Patient/Legal Representative

Witness

MD

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Weymouth Endoscopy, LLC
1085 Main Street, South Weymouth
TEL: 781-331-2922 FAX: 781-335-5702

INSURANCE WAIVER OF LIABILITY

Without a referral, your insurance may not pay for services rendered. If your insurance determines that a particular service is not covered without a referral, your insurance may deny payment for that service.

As your physician, I believe this service is medically necessary, but it may not be payable under your insurance policy. In this specific circumstance, your insurance may deny payment for this service.



I have been informed by my physician's office that I am responsible for payment of this service should my insurance company deny payment.

Signature

Date