Franklin Medical Group, PC
Digestive Disease Center

60 Westwood Ave. Waterbury, CT 06708 (ph. 203-574-3007) (fax 203-573-1739)
1154 Highland Ave. Cheshire, CT 06410 (ph. 203-709-4818) (fax 203-709-5234)
3801 East Main St. Waterbury, CT 06705 (ph. 203-709-4001) (fax 203-709-5290)

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Michele Pierce, PA-C

Please read and sign the consent forms and complete the patient information forms.

We must receive these completed forms before your Procedure can be performed.

You can mail these forms to the Waterbury address
Listed above or they may be faxed to our office at 203-573-1739.

Thank You.

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PROCTOSIGMOIDOSCOOPY (FLEX) (HOSPITAL)

Your doctor has requested that you receive a special examination. This instruction sheet is designed to tell you about this procedure and how you will be prepared for it. Please ask your nurse or doctor if you have any questions not covered here.

WHAT IS THIS TEST?

A proctosigmoidoscopy (flexible sigmoidoscopy) is recommended when a change in bowel habit, diarrhea, pain, or bleeding from the rectum occurs. The examination is performed with a flexible fiberoptic sigmoidoscope. The doctor will be able to visualize the lining of the rectum and most of the left colon (called the sigmoid and descending colon).

Special medications will be given to ease any discomfort. All regular medications should be taken on the day of the procedure (after you arrive home) except as directed by the doctor.

DO NOT EAT OR DRINK AFTER MIDNIGHT THE NIGHT BEFORE THE PROCEDURE

You must have someone drive you home after this procedure. PLEASE CHECK WITH YOUR DOCTOR IF YOU ARE TAKING ASPIRIN PRODUCTS OR BLOOD THINNERS TO DETERMINE IF HE WANTS THEM STOPPED BEFORE THE PROCEDURE.

IT IS IMPORTANT TO LET THE DOCTOR KNOW IF YOU HAVE ANY ALLERGIES.

DAY OF THE PROCEDURE:

Use two Fleet enemas 1 to 1½hrs. before you are due to be at the hospital. Insert the first one, retain it for approximately 15 minutes, evacuate it, and then repeat the procedure with the second one.

YOUR PROCEDURE IS SCHEDULED FOR: ____

AT:________________________HOSPITAL, BY DR:__________________________________

_____ **NAUGATUCK VALLEY SURGICAL CENTER**: **160 Robbins ST. Waterbury, CT. 06708**
Someone from Naugatuck Valley Surgical Center will call you 2 days before your procedure with your procedure time.

_____ **ST. MARY'S HOSPITAL: 56 Franklin St. Waterbury, CT. 06706**
Report to the second floor, admitting office.
THE HOSPITAL WILL CALL YOU THE DAY BEFORE YOUR PROCEDURE WITH YOU TIME.

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The following is a list of products containing aspirin, aspirin-like compounds, Ibuprofen, and Naproxen sodium. **PLEASE DO NOT TAKE THESE PRODUCTS FOR ONE WEEK PRIOR TO YOUR PROCEDURE.**

Prescription products containing aspirin or aspirin-like compounds:

Actron
Cataflam
Celebrex
Darvon Compound 65
Disalcid Capsules/Tablets
Dolobid
Easprin Tablets
Empirin with Codeine Tablets
Equagesic Tablets
Fiorinal Capsules/Tablets
Fiorinal with Codeine Capsules/Tablets
Ha1fprin
Lodene
Lortab ASA Tablets
Magsal Tablets
Mono-Gesic Tablets
Norgesic & Norgesic Forte Tablets
Orudis
Percodan and Percodan-Demi Tablets
Plavix
Ponstel
Relafen
RobaxisaI Tablets
Salflex Tablets
Soma Compound Tablets
Soma Compound with Codeine Tablets
Synalgos-DC Capsules
Talwin Compound Tablets
Toradol
Trilisate TabletslLiquid
Vioxx

Prescription Products Containing Ibuprofen:

Motrin Tablets
Children's Advil Suspension
Children" s Motrin Suspension

Prescription Products Containing Naproxen/Naproxen Sodium:

Anaproxl Anaprox DS Tablets
Naprelan
Naprosyn Suspension/Tablets

Nonprescription Products Containing Ibuprofen:

Advil Caplets/Tablets Advil
Cold, Sinus Caplets
Bayer Select Ibuprofen Pain Relief Formula Caplets
Dristan Sinus Caplets
Haltran Tablets
Ibuprofen Caplets/Tablets
Midol IB Tablets
Motrin IB Caplets/Tablets
Nuprin Ibuprofen Caplets/Tablets
Sine-Aid IB

Non-Prescription Products Containing Aspirin and/or Aspirin-like Compounds:

Alka-Seltzer Antacid/Pain Reliever
Effervescent Tablets
Alka-Seltzer Plus Cold Medicine Tablets
Anacin Caplets/Tablets
Anacin Maximum Strength Tablets
Arthritis Pain Formula Tablets
Arthritis Strength Bufferin Tablets
Ascriptin Caplets/Tablets
Ascriptin A/D Caplets
Aspergum
Bayer Aspirin Caplets/Tablets
Bayer Children's Chewable Tablets
Bayer Plus Tablets
Maximum Bayer Caplets/Tablets
8 Hour Bayer Extended Release Tablets
BC Powder
BC Cold Powder
Buffaprin Caplets/Tablets
Bufferin Arthritis Strength Caplets
Bufferin caplets/Tablets
Cama Arthritis Pain Reliever Tablets
Doan's Pills Caplets
Ecotrin Caplets/Tablets
Empirin Tablets
Excedrin Extra Strength Caplets/Tablets
Midol Caplets
Mobigesic Analgesic Tablets
Norwich Tablets
P-A-C Analgesic Tablets
Pepto Bismol Liquid/Tablets
Sine-Off Tablets, Aspirin Formula
St. Joseph Adult Chewable Aspirin
Therapy Bayer Caplets
Trigesic
Ursinus Inlay-Tabs
Vanquis Analgesic Caplets

Alka-Seltzer Plus Cold Medicine

Non-Prescription Products Containing Naproxen Sodium:

Aleve Caplets/Tablets

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PROCTOSIGMOIDOSCOPY

This is an explanation of the procedure you are going to have. After you have read it, you will be asked to sign it; giving the doctor permission to perform the test.

A proctosigmoidoscopy (flexible sigmoidoscopy) is recommended when a change in bowel habit, diarrhea, pain, or bleeding from the rectum occurs. The examination is performed with a flexible fiber optic sigmoidoscope. This test can usually be performed in the office without medication. The doctor will be able to visualize the lining of the rectum and most of the left colon (called the sigmoid and descending colon).

You will be asked to lie on your left side. The instrument will be inserted into the rectum. The doctor will put air through the instrument to open the pathway through the colon. This may cause some abdominal discomfort. Biopsies (small tissue samples) of suspicious areas can be taken and sent to the laboratory.

As with any test, there may be complications. We want you to be aware of these possibilities. If bleeding from the site of biopsy is more than usual, cautery may be needed. Rarely, severe uncontrolled bleeding may require blood transfusions or even surgery. Perforation or a tear in the lining of the bowel may occur. This complication may require surgery.

You may feel bloated or gassy for several hours after the test because of air introduced during the test. Any other symptoms should be reported to the doctor immediately.

I UNDERSTAND THE BENEFITS AND POSSIBLE RISKS ASSOCIATED WITH THIS PROCEDURE AND GIVE PERMISSION TO DR__________________________TO PERMORM THE ABOVE TEST

TO OUR MEDICARE PATIENTS: Medicare deems this procedure "routine" and, therefore, will only provide reimbursement if performed for one of the following diagnoses: COLITIS, COLONIC POLYP, DIVERTICULITIS, HEMATOCHEZA, CROHN'S DISEASE, RECTAL BLEEDING. Your signature indicates that you understand and accept this principle and are responsible for payment.

Print Name:____

PATIENT SIGNATURE:________________________________ Date:________________

WITNESS:____

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SUMMARY OF NOTICE OF PRIVACY PRACTICES

By Law, we are required to provide you with our Notice of Privacy Practices. This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to request confidential communications.
5. The right to a report of disclosures of your information.
6. The right to a paper copy of this notice.

Please be advised that we may:

1. Call your name when the doctor is ready to see you.
2. Leave test results or messages on your answering machine.
3. Take your charts out of the office for dictation, review, or to see you in our satellite office.
4. Call your place of employment and ask to speak with you.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally received a copy of the DIGESTIVE DISEASE CENTER Notice of Privacy Policies on the date below.

Signature:_______________________________________ Date:_________________________

Patient (print)____

Information about Agent (attach appropriate documentation):

Agent:____

Title:____

I grant permission to DIGESTIVE DISEASE CENTER to share my Protected Health Information with the following individuals:

Name:__________________________Phone#_______________Relationship to Patient____________

Name:__________________________Phone#_______________Relationship to Patient____________

Name:__________________________Phone#_______________Relationship to Patient____________

Signature of Patient:___________________________________ **Date:**______________________

FRANKLIN MEDICAL GROUP, P.C.
DIGESTIVE DISEASE CENTER

(PRINT) NAME:_______________________________________DOB:_____________

E-MAIL ADDRESS:____

Ethnicity:

☐ Hispanic or Latino

☐ Not Hispanic or Latino

Race:

☐ White

☐ Black or African American

☐ Asian

☐ American Indian or Alaska Native

☐ Native Hawaiian or Pacific Islander

☐ Unknown

☐ Hispanic

☐ Mixed Racial Heritage (two or more race)

Signature:____Date:____________________