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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Russell Parvin, M.D.
Michele Pierce, PA-C

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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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INSTRUCTIONS for COLONOSCOPY MOVIPREP

1. **ON THE DAY BEFORE THE PROCEDURE: Today, clear liquids only, NO SOLID FOOD.**

a) In the morning prepare your MoviPrep ~ one liter solution according to the package instructions. The Movi carton contains 4 pouches and one disposable container for mixing. Mix per package directions with luke warm water. You may refrigerate the preparation to make it more palatable.

b) You must drink at least 8 ounces every hour of clear liquids ALL DAY LONG, which includes Jello and non-dairy sherbet. (see attached list).

c) You can NOT have solid foods.

d) At approximately 4:00 PM (or after getting home from work) you are to begin the first portion of the MoviPrep (one liter). Drink one 8 oz. glass of prep every 15 minutes over the next hour. As soon as you have finished this liter, drink 16 ounces. of a clear liquid. This will induce diarrhea (which is normal) to cleanse the bowel. (Mix 2nd portion of the prep in container and chill)

e) Approximately 1 ½ hours later drink the second portion of the MoviPrep (1 Liter) as instructed above in letter d.

2. **You are to have nothing to eat or drink after midnight the night before the procedure.**

3. Someone must be available to drive you home following the procedure.

4. Aspirin products, Ibuprofen, Aleve, Naproxen, iron tablets, and blood thinners (i.e. Coumadin, Heparin, Naprosyn must be discontinued one week before the procedure).

5. It is important to let the doctor know if you have any allergies.

6. The following medication should be taken with a sip of water before your procedure:
_____

7. If you are diabetic, you are to take your medication as follows:
_____

8. All other medications should not be taken until after the procedure.

9. On the day of the procedure; you must bring with you a list of all medication(s) that you take on a regular basis so that a copy can be made.

Your procedure is scheduled for _____at _____Hospital with 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.

CLEAR LIQUID DIET

The day before the procedure, it is important to have approximately 4oz.to 8oz. of fluid from the following list, every hour while you are awake.

Clear liquids include:

- WATER
- ANY LEMON-LIME SODAS (Ginger ale, Sprite, 7-UP, etc.)
- Clear juices (apple, white grape, cranberry, etc.)
- Broth made from bouillon cubes (no noodles)
- Jello (NO RED)
- NoN-Dairy sherbet (lemon Italian ice, etc.)
- Gatorade
- Black Tea or black coffee (you may use sweetener, but no milk or coffee creamer)

You may also drink Ensure, a dietary supplement; however, you must have no more than 2 bottles. **Dr. Lyall prefers his patients not drink Ensure.**

YOU ARE NOT TO HAVE ANY SOLID FOODS.

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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 with Codeine Capsules/Tablets
Halfprin
Lodene
Lortab ASA Tablets
Magsal Tablets
Mono-Gesic Tablets
Norgesic & Norgesic Forte Tablets
Orudis
Percondan and Percodan-Demi Tablets
Plavix
Ponstel
Relafen
Robaxisal Tablets
Salflex Tablets
Soma Compound Tablets
Synalgos-DC Capsules
Talwin Compound Tablets
Toradol
Trilisate Tablets/Liquid
Vioxx

Prescription Products Containing Ibuprofen:

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

Prescription Products Containing Naproxen/Naproxen Sodium:

Anaprox/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
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 Arthitis Strength Caplets
Bufferin caplets/Tablets
Cama Arthritis Pain Reliever Tablets
Doan's Pills Caplets
Ecotrin Caplets/Tablets
Empirin Tablets
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

Non-Prescription Products Containing Naproxen Sodium:
Aleve Caplets/Tablets

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COLONOSCOPY CONSENT

A Colonoscopy involves the passage of a long flexible digital optic instrument through the anus, into the rectum and into the large intestine (Colon). This allows the physician to visualize the interior of the rectum and the colon. A Colonoscopy is indicated for detection of Polyps (abnormal round, flat or mushroom like growths of tissue from the wall of the intestine), tumors, bleeding areas, colitis (inflammation of the lining of the colon), diverticular disease (out-pouching of the bowel wall), unexplained abdominal pain, strictures (narrowed areas in the colon), or obstruction (blockage), etc. During this procedure, biopsies of the suspicious areas can be taken, bleeding areas can be treated and polyps can be removed and sent to the laboratory for testing. Polyps are usually benign (non-cancerous), but may occasionally contain an area of cancer or may develop into a cancer. If indicated the polyp will be removed with a snare (wire loop) placed around the polyp and electric current used to sever the attachment of the polyp to the intestinal wall. It is important for the colon to be extremely clean for the best possible examination. Specific instructions will be given to you regarding the preparation for your colonoscopy and instructions regarding intake of your regular medications and over the counter medications before the test. **ASPIRIN PRODUCTS AND IRON TABLETS SHOULD BE DISCONTINUED FOR 1 WEEK BEFORE THE TEST**.

When you arrive for the test, you will be placed on a monitor which will check your blood pressure, pulse and heart rhythm. An intravenous line will be inserted into a vein so that you can receive medications. **IT IS IMPORTANT TO LET YOUR DOCTOR KNOW IF YOU HAVE ANY ALLERGIES**. Medications will be given to you through the intravenous line to minimize discomfort and relax you for the procedure. These medications may cause localized irritation and/or drug reaction. After receiving sedatives, you will not be able to drive home. **ANY PATIENT RECEIVING SEDATION/ANESTHESIA WILL NOT BE ALLOWED TO DRIVE HOME.**

Possible complications of A Colonoscopy include, but are not limited to bleeding, and tearing or perforation of the bowel wall. These complications, should they occur, may require surgery, hospitalization, repeat colonoscopy, and/or blood transfusion. Perforation of the bowel is a known, but rare complication which can occur at a rate of 1 per 1,000 colonoscopies. Bleeding usually after a polyp removal can occur at a rate of 1 per 1,000 colonoscopies and may occur up to two weeks after a polyp is removed. Other extremely rare but serious or possibly fatal risks include: difficulty breathing, heart attack, and stroke. Polyps especially small, can be missed and in rare cases a colon cancer can be missed. Colonoscopy does not guarantee that you will not develop colon cancer, but removing polyps is documented to significantly decrease your risk of colon cancer in the future.

Alternatives of Colonoscopy include fecal occult blood testing, Radiologic imaging tests, Flexible Sigmoidoscopy (Office based test without sedation which examines only one third of the colon) and surgery. These tests have their own limitations and benefits. On rare occasions, the colonoscope cannot be advanced through the entire colon and therefore in these patients alternative tests may be useful. Some patients may require surgery to remove a large polyp if this cannot be safely removed by colonoscopy.

You may feel bloated and gassy for several hours after your procedure because of the air introduced into the colon during the test. Any other symptoms should be reported to the doctor immediately. If you have any questions about your procedure, they will be answered for you before you sign this form. **(203) 574-3007**

I have read and fully understand the benefits, alternatives, limitations and possible risks associated with Colonoscopy and give permission to Dr._____ to perform the above test.

PATIENT SIGNATURE:_____WITNESS_____

PRINT NAME:_____DATE:_____

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MEDICATION RECORD

PLEASE BRING A COPY OF YOUR MEDICATION LIST WITH YOU TO THE HOSPITAL or YOUR OFFICE VISIT.

NAME:_____D.O.B:_____SS#_____

ADDRESS:_____

PRIMARY M.D._____PHONE#_____

CARDIOLOGIST NAME:_____PHONE#_____

ALLERGIES:_____

Pharmacy:_____Town/Address:_____Phone#:_____

EMERGENCY CONTACT NAME:_____PHONE_____RELATIONSHIP_____

PRESCRIBED MEDICATION	DOSE	FREQUENCY	PRESCRIBING DOCTOR

*OVER THE COUNTER MEDICATIONS:_____

_____

*ALTERNATIVE MEDICATION:_____

_____

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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, PC
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:_____