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

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 ENTEROSCOPY

1. You are to have nothing to eat or drink after midnight the night before the procedure.
2. Someone must be available to drive you home following the procedure.
3. Aspirin products, Ibuprofen, Aleve, iron tablets and blood thinners (i.e. Coumadin, Heparin, Naprosyn) must be discontinued one week before the procedure.
4. It is important to let the doctor know if you have any allergies.
5. The following medications should be taken with a small sip of water before going for your procedure.

   _____

   Any other medications should not be taken until after the procedure.

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

   _____

7. Please bring with you a list of all medications that you take on a regular basis.

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 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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ENTEROSCOPY CONSENT

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

This test is named after the three areas of the body to be examined: Esophago (esophagus), gastro (stomach), and duodenum (first part of the small bowel) and then to the jejunum as far as possible. A flexible fiberoptic instrument called an endoscope is passed through the mouth and the back of the throat into the upper intestinal tract.

Abnormalities suspected by x-ray and other abnormalities too small to be detected by x-ray can all be examined by this test. Biopsies (small tissue samples) of suspicious areas can be taken through the instrument and sent to the laboratory. An alternative would be an abdominal operation.

You will be asked to have nothing to eat or drink after midnight the night before the test. The doctor will tell you whether to take any of your regular medications. When you arrive for the test, the nurse will check your pulse and blood pressure and insert an intravenous line into a vein so that you can receive medications. **IT IS IMPORTANT TO LET THE DOCTOR KNOW IF YOU HAVE ANY ALLERGIES.** Your throat may be sprayed with an unpleasant tasting liquid, which numbs the throat so that you will not gag. Medications will be given through the intravenous line to help relax and sedate you. I also consent to the administration of such anesthetics and sedating medications, which may be necessary for the performance of this operation or procedure, understanding that there are risks associated with anesthesia and sedation.

The test takes about 15-30 minutes depending on whether or not biopsies are taken. When the endoscope is in place, the doctor will put air through it to open the pathway through the upper intestinal tract. This air may make you feel full and uncomfortable as if you have to burp. If biopsies are performed, a small sample of tissue about the size of the head of a pin will be removed. The area may bleed a small amount but usually heals without problems. Since the lining of the intestinal tract lacks nerve endings, you will not feel the biopsies being taken.

As with any test, there may be complications. We want you to be aware of these possibilities. If bleeding from the site of biopsy or polyp removal 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 throat, esophagus, stomach, or duodenum may occur. This may be managed by simply aspirating the fluid until the tear closes or may require surgical closure. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that here are no guarantees concerning results from this operation or procedure. Inflammation of the vein (phlebitis) may occur from the intravenous line or the medications. This may produce a tender lump, which may last for several weeks to months. This eventually goes away. Allergic reactions, drug reactions, and complications from unrelated diseases such as heart attack or stroke may occur. Extremely rare is the remote possibility that death may occur.

As soon as possible following the procedure, you will be given fluids and a light snack prior to your discharge. NO PATIENT RECEIVING SEDATIVE MEDICATION WILL BE ALLOWED TO DRIVE HOME. You may experience a sore throat for 24 hrs after the test. You may feel bloated and gassy for several hours after the test because of the air introduced during the test. Any other symptoms should be reported to the doctor immediately.

If you have any questions about this test, they will be answered for you before you sign this consent form and the hospital/outpatient surgical facility consent form. **YOUR DOCTOR WILL DISCUSS YOUR PROCEDURE WITH YOU PRIOR TO YOUR DISCHARGE.**

I UNDERSTAND THE BENEFITS AND POSSIBLE RISKS ASSOCIATED WITH THIS PROCEDURE AND GIVE PERMISSION TO DR._____TO PERFORM THE ABOVE TEST.

PRINT PATIENT NAME:_____DATE:_____

PATIENT SIGNATURE:_____DATE:_____

WITNESS SIGNATURE:_____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, 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:_____