



COLONOSCOPY INSTRUCTIONS FOR PATIENTS | RALEIGH ENDOSCOPY LOCATION

Procedure Date: _____ Arrival Time: _____ Procedure Time: _____

Procedures are only done at one of the following locations. Circle/highlight your location:

Raleigh Endoscopy Center, Cary
1505 SW Cary Parkway, Suite 202 Cary, NC 27511

Raleigh Endoscopy Center, Main
2417 Atrium Drive, Suite 101, Raleigh, NC 27607

Raleigh Endoscopy Center, North
8300 Health Park Drive, Suite 210, Raleigh, NC 27615

WakeMed Cary Hospital
1900 Kildaire Farm Road, Cary, NC 27518

LOCATION AND ARRIVAL TIMES

Raleigh Endoscopy Center Patients:

Please arrive at the endoscopy center **ONE HOUR** prior to your procedure. Patients having procedures at the Raleigh Endoscopy Center(s) are not required to have Covid testing prior to the procedure. If your procedure time is 7:30am, please arrive at 6:45am. The endoscopy center opens at 6:45am, please do not arrive any earlier than 6:45am.

WakeMed Cary Hospital Patients:

Please arrive to your scheduled Colonoscopy appointment **ONE HOUR & 30 MINUTES** before your scheduled appointment time for check in at WakeMed. This is a requirement by WakeMed. If your procedure is at 9:30am you will need to arrive at 8:00am for check in.

Please Read and Follow These Directions Very Closely.

Failure to complete prep correctly may result in rescheduling your procedure.

ITEMS TO PURCHASE:

- 1) **Prescription Prep Solution:** This is the medication we sent directly to your chosen pharmacy. You will receive one of the following kinds of prep from your pharmacy:
 - Suprep (Generic Name: Sodium Sulfate, Potassium Sulfate and Magnesium Sulfate)
 - Suflave
 - Clenpiq
 - Plenvu
 - Sutab
 - Golytely/Nulytely/Trilyte and or PEG 3350
- 2) Pick up a small bottle of MiraLAX from your local drug store. No prescription required.
- 3) Zinc Oxide barrier cream such as Desitin. This helps soothe any skin irritation.

CALL CARY GASTROENTEROLOGY IF YOU:

- 1) Require **ANTIBIOTICS** for invasive procedure.
- 2) Have a **LATEX ALLERGY**.
- 3) Are on a blood thinner (ex: Coumadin, Pradaxa, Xarelto, Eliquis, Arixtra, Plavix, Effient) or if you take more than 81mg of ASPIRIN per day.
- 4) Taking any weight loss medications.

Please remember, your procedure will be cancelled if you do not stop weight loss medications 7 days prior to your procedure and are required to start fasting 24 hours before your procedure date.

THE FOLLOWING ARE ABSOLUTE REQUIREMENTS FOR YOUR PROCEDURE:

- **A licensed driver (age 18 and older)** **MUST** accompany you at check-in and remain during the entirety of your procedure.
- **Taxis are prohibited. Driving yourself is prohibited.** You cannot walk or ride a bike home. Plan on spending up to 3 hours at the procedure center. Do not bring jewelry or valuables.
- Wear comfortable clothing. **DO NOT** wear contact lenses. Bring warm socks.
- **All medical clearances must be in our office prior to your procedure.**
- **NOTHING BY MOUTH** 4 hours prior to your procedure.

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PART 1 OF 3 FOR PREP INSTRUCTIONS (IMPORTANT)

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7 DAYS PRIOR TO YOUR PROCEDURE: Day/Date: _____

- **STOP:** Iron supplements, Vitamin E., St. John's Wort, Fish Oil and Gingko products.
- **STOP:** Anti-inflammatory drugs (NSAIDS): Ibuprofen, Advil, Motrin, Aleve, Celebrex, Mobic.
- **STOP:** ALL WEIGHT LOSS MEDICATIONS
- **TYLENOL** may be used freely, including the day of procedure.
- Your physician may ask you to stop blood thinners, including aspirin, between now and 5 days prior to your procedure. Check with Cary Gastroenterology to clarify this.
- **DIABETIC PATIENTS: PLEASE REVIEW PAGE 8 FOR ADDITIONAL INFO ON MEDICATIONS**

3 DAYS PRIOR TO YOUR PROCEDURE: Day/Date: _____

IMPORTANT DIET RESTRICTIONS:

- **NO** fruits/vegetables with seeds such as cucumbers, tomatoes, squash, broccoli, beans, kiwi, strawberries and or raspberries.
- **NO** granola bars, high grain cereals/breads, bagels, oatmeal, nuts, corn, or popcorn.

2 DAYS PRIOR TO YOUR PROCEDURE AT 6:00PM: Day/Date: _____

- **Required MiraLAX Preparation:**
Dissolve 2 capfuls/34 grams of MiraLAX in 16oz of liquid and drink over 5 – 10 minutes.
Repeat the mixture 1 hour later.

***1 DAY BEFORE TO YOUR PROCEDURE (PREPERATION DAY):** Day/Date: _____

FASTING ONLY:

Starting at 7:00 AM: You are to only consume **CLEAR LIQUIDS** for the remainder of the day.

- **DO NOT** drink anything colored red or purple.
- **DO NOT** drink dark colas. (example: Coca Cola, Pepsi)
- **DO NOT** drink milk.
- **DO NOT** drink alcohol.
- **DO NOT** drink coffee.

Approved Sample Clear Liquids	
➤	Water, Lemon Gatorade, Sprite, Ginger Ale and or Mountain Dew
➤	Chicken broth or Vegetable broth
➤	Popsicles (without pulp or fruit pieces; no red or purple)
➤	White grape, Apple, or White cranberry juice.
➤	Clear hard candy (lemon drops only)

PART 2 OF 3 FOR PREP INSTRUCTIONS (IMPORTANT)

TAKE THE FIRST DOSE OF YOUR PREP AT 6:00 PM THE NIGHT BEFORE YOUR PROCEDURE.

Follow the instructions below for the particular prep you were prescribed:

☐ **SUPREP:** (Generic Name: Sodium Sulfate, Potassium Sulfate and Magnesium Sulfate)

- Pour ONE (1) 6-ounce bottle of SUPREP liquid into the mixing container provided.
- ADD cool drinking water to the 16-ounce line on the container and mix.
- Drink ALL the liquid in the container.
- You MUST drink two (2) more 16-ounce containers of water over the next hour.

☐ **CLENPIQ:**

- The kit includes two (2) bottles of premixed solution.
- Drink ALL of one pre-prepared bottle. No need to mix with anything. (Either bottle is fine, as they are the same solution).
- Using the cup included with your kit, drink 5 (FIVE) 8-ounce cups of clear liquid (upper line) over the next 5 hours.

☐ **SUFLAVE:**

- Open 1 flavor-enhancing packet and pour the contents into 1 bottle
- Fill the provided bottle with lukewarm water up to the fill line. After capping the bottle, gently shake the bottle until all the powder has mixed well (dissolved). For best taste, refrigerate the solution for an hour before drinking. **DO NOT FREEZE.** Use within 24 hours.
- Drink 8 ounces of the solution every 15 minutes until the bottle is empty. Drink an additional 16 ounces of water during the evening.

□ **SUTAB:**

- Open one bottle of 12 pills.
- Fill the provided container with 16 ounces of water (up to the fill line). Swallow each tablet with a sip of water, drinking the entire amount over 15 to 20 minutes.
- One hour after the last tablet is ingested, fill the provided container a second time with 16 ounces of water (up to the fill line) and drink the entire amount over 30 minutes.
- Approximately 30 minutes after finishing the second container of water, fill the provided container with 16 ounces of water (up to the fill line) and drink the entire amount over 30 minutes. Continue drinking water only until the second dose.

□ **PLENVU: Please use the 2-day SPLIT dose instructions**

- Use the mixing container to mix contents of the DOSE 1 POUCH with 16 ounces of water by shaking or using a spoon until completely dissolved.
- Slowly drink the 16-ounce mixed solution. Try to finish it within 30 minutes.
- Refill the container with 16 OUNCES of clear liquid and drink over 30 minutes.

□ **GOLYTLEY, NULYTELY, GAVILYTE, HALFLYTELY OR TRILYTE, PEG3350:**

- ADD water to the "Fill To" level mark of the prep container. SHAKE until completely dissolved (this can be done in advance, then chilled).
- Drink HALF the prep solution. You should drink a minimum of 8-ounces of the solution every 10 MINUTES. You can drink it faster if you are able. Continue drinking clear liquids until bedtime.

**IF YOU DO NOT HAVE A BOWEL MOVEMENT BY 9:00PM,
PLEASE CALL OUR ON-CALL PROVIDER AT (919) 816-4948.**

MEDICATION ADJUSTMENTS:

Please take your blood pressure or heart medications at your normal times with sips of water. If you are on insulin or oral diabetes medications, please consult with your physician to discuss adjusting these medications. Typically, we recommend **NOT** taking your diabetes medications the day of the procedure, as you will be fasting that day. **STOP** all diuretics (water pills) the day before your procedure.
Do not take them the day of the procedure.

PART 3 OF 3 FOR PREP INSTRUCTIONS (IMPORTANT)

MUST TAKE 6 HOURS PRIOR TO ARRIVAL TIME FOR PROCEDURE

PROCEDURE DAY/Date: _____ Time to Start 2nd Part _____

❖ 6 HOURS PRIOR TO YOUR ARRIVAL TIME

Take the 2nd PART of your prep, as follows:

☐ **SUPREP:** (Generic Name: Sodium Sulfate, Potassium Sulfate and Magnesium Sulfate)

- Pour ONE (1) 6-ounce bottle of SUPREP liquid into the mixing container provided.
- ADD cool drinking water to the 16-ounce line on the container and mix.
- Drink ALL the liquid in the container.
- You MUST drink two (2) more 16-ounce containers of water over the next hour.

☐ **CLENPIQ:**

- Drink the second bottle of premixed solution.
- Drink an ADDITIONAL 4 (FOUR) 8-ounce cups of clear liquid (upper line).
- Drink the entire container over 60-minutes.
- Using the cup included with your kit, drink 5 (FIVE) 8-ounce cups of clear liquid (upper line) over the next 5 hours.

☐ **SUFLAVE:**

- Open 1 flavor-enhancing packet and pour the contents into 1 bottle
- Fill the provided bottle with lukewarm water up to the fill line. After capping the bottle, gently shake the bottle until all the powder has mixed well (dissolved). For best taste, refrigerate the solution for an hour before drinking. DO NOT FREEZE. Use within 24 hours.
- Drink 8 ounces of the solution every 15 minutes until the bottle is empty. Drink an additional 16 ounces of water.

☐ **GOLYTELY, NULYTELY, GAVILYTE, HALFLYTELY OR TRILYTE, PEG3350:**

- Drink the remaining HALF of the prep solution, drinking a minimum of 8 ounces of the solution every 10 minutes.

□ **PLENVU: Please use the 2-day SPLIT dose instructions**

- Use the mixing container to mix the contents of Dose 2 (Pouch A and Pouch B) with at least 16 ounces of water until dissolved. This may take a few minutes to mix.
- Drink the contents slowly over 30 minutes. Drink an ADDITIONAL 16-ounces of clear liquid or water.

□ **SUTAB:**

- Open the second bottle of 12 tablets.
- Fill the provided container with 16 ounces of water (up to the fill line). Swallow each tablet with a sip of water and drink the entire amount over 15 to 20 minutes.
- One hour after the last tablet is ingested, fill the provided container a second time with 16 ounces of water (up to the fill line) and drink the entire amount over 30 minutes.
- 30 minutes after finishing the second container of water, fill the provided container again with 16 ounces (up to the fill line) and drink the entire amount over 30 minutes.
- If you experience preparation related symptoms such as nausea, bloating, cramping, pause or slow the rate of drinking the additional water until symptoms diminish.

***** IMPORTANT *****

You are to have **NOTHING BY MOUTH**
beginning **4 hours** prior to your procedure.

This includes clear liquids, breath mints, gum, and candies.

**Failure to follow these instructions will result in
delay or cancellation of your procedure.**

If you do have any questions regarding your prep process,
please call us at 919-816-4948 option 3.

Weight Loss/Diabetic Medications:

If you are taking any of the following diabetic and or weight loss medications or intend to take any of these medications prior to your scheduled procedure and have not notified the procedure schedulers or the doctor's team that you are on these medications when scheduling, please notify your doctors medical team immediately. You may need additional information on your preparation in regards to these medications.

- Ozempic (Semaglutide)
- Rybelsus (Oral Semaglutide)
- Mounjaro (Tirzepatide)
- Wegovy (Semaglutide)
- Victoza (Liraglutide)
- Saxenda (Liraglutide)
- Byetta (Exenatide)
- Trulicity (Dulaglutide)
- Zepbound (Tirzepatide)
- Adipex-P or Lomaira (Phentermine)

If you do have any questions regarding your prep process,
please call us at 919-816-4948 option 3.

Cary Gastroenterology Reschedule/Cancellation Policy

To best serve all patients, we are informing you of our reschedule, cancellation and no-show policy. Please note that failing to cancel or reschedule an office visit or procedure in a timely manner leads to negative impacts on Cary Gastroenterology and our patients. We ask that you honor your scheduled appointment and ensure prompt communication with our office should an appointment of any kind need to be cancelled or rescheduled. All patients must provide at minimum notice for cancellation as per below.

Rescheduling, Cancellation, No Show Policy - Office Visits and Procedures Cary Gastroenterology allows no more than three reschedules or cancellations per patient, for both office visits and procedures. If you have reached your allotted reschedule and/or cancellation limit, per our policy, no further appointments will be scheduled with Cary Gastroenterology. You will be charged for late cancellations/reschedules and no-show appointments, as indicated below.

Office Visits: We require a 72-hour notice to reschedule or cancel an office visit. Failure to provide adequate notice will result in a late reschedule/cancel fee of \$100.00. Failure to show for a scheduled appointment will be charged \$100.00. We will allow one no-show per patient. After the second no-show, no further appointments will be schedule with Cary Gastroenterology.

Procedures: We require a 5-business day notice to reschedule/cancel a procedure. Failure to provide adequate notice will result in a late reschedule/cancel fee of \$100.00. If you have rescheduled your procedure twice, we will require a deposit of \$200 for the final reschedule. Deposits for procedures that are not cancelled per this policy are nonrefundable. Failure to show for a scheduled procedure will be charged \$200.00. We will allow one no-show per patient. After the second no-show, in addition to the no show fee, no further appointments will be schedule with Cary Gastroenterology.

Patient Signature

Date

Cary Gastroenterology Associates
Colonoscopy Consent Form

Your physician has requested that you undergo a procedure called Colonoscopy. Colonoscopy is a procedure that enables the physician to see inside the colon or large intestine. The colon is examined with a long flexible tube called a colonoscope. This instrument is a lighted tube composed of either very thin flexible fibers, or a tiny video camera that enables the physician to see around bends or corners.

This procedure is useful in detecting diseases of the large intestine, including polyps, cancer and other diseases that can result in diarrhea, weight loss, abdominal pain or blood in the stool. If an abnormality is detected it often can be biopsied or removed. Polyps can often be burned out with a procedure called polypectomy which uses electric current to burn the polyps off the wall of the colon.

As with any examination certain risks exist. These include but are not limited to: bleeding, perforation, medication reactions, life threatening events, and missed lesions. With this procedure there is the risk of bleeding from biopsy or polypectomy site. Bleeding can often be stopped using special tools at the very same time of colonoscopy. Rarely, blood transfusions or surgery may be required in this situation. Perforation or puncture of the colon is an additional risk of this procedure, although this is a rare occurrence. If perforation occurs surgical correction is necessary. Medication reactions and life threatening events are rare occurrences and you are monitored closely for them during and following the procedure. As with many tests, it is not perfect and lesions can be missed. **Every effort is made to minimize chances of these risks.**

If you have any questions concerning this test, they will be answered for you before you sign this form.

I certify that I have read/been read and understand the contents of this informed consent.

In addition, all of my questions have been answered; and all complications, risks, and benefits have been explained to my satisfaction.

I hereby authorize Dr. _____ and/or such assistants as may be selected by him to perform the above-mentioned procedure on _____.

(Name of Patient)

Patient Signature _____

Date _____

Cancellation and rescheduling fees will be assessed. Please ensure understanding of Cary Gastroenterology's policies for cancelling and rescheduling appointments.

06/2012

Compound Authorization for Release of Information
Cary Gastroenterology Associates/Women's Center for GI Health

Name: _____ Date of Birth: _____

Cary Gastroenterology Associates/Women's Center for GI Health, is authorized to release protected health information about the above-named patient to the entities below.

The following individual is authorized to access my personal health information:

Name: _____

Telephone Number: _____

Relationship: _____

The following information may be released to this person

- ☐ Financial
- ☐ Medical, including office visit reports, test results, pathology finding, etc.

The following individual is authorized to access my personal health information:

Name: _____

Telephone Number: _____

Relationship: _____

The following information may be released to this person

- ☐ Financial
- ☐ Medical, including office visit reports, test results, pathology finding, etc.

Voice Mail for Appointment:

May we leave appointment information and/or a name and number to call our facility on your voicemail?

- ☐ Yes, leave appointment and contact info on voicemail
Phone number is: _____
- ☐ No, do not leave any information on voicemail

Voice Mail for Medical Results:

May we leave medical results/information and/or a name and number to call our facility on your voicemail?

- ☐ Yes, leave medical results/information on voicemail
Phone number is: _____
- ☐ No, do not leave any information on voicemail

Clinical Trials:

Cary Gastroenterology Associates is active in clinical research trials and receives remuneration for patients who enroll in the studies. Would you like to be contacted if a clinical trial becomes available that the physician feels may benefit you as a patient?

- ☐ Yes, please contact me if my physician feels I may benefit from a clinical trial. I further authorize the contracted clinical research staff to review my demographic and medical history in order to determine my candidacy for a study.
- ☐ No, do not contact me regarding clinical trials.

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Signature of Patient or Personal Representative

Date

Raleigh Endoscopy Center Patient Health History Sheet:

Please complete this form and bring it with you on the day of your procedure.

Locations:

Main: 2417 Atrium Dr. (Phone) 919-791-2060 **North:** 8300 Health Park (Phone) 919-256-7980 **Cary:** 1505 SW Cary Parkway (Phone) 919-792-3060

Patient Name _____ Date of Birth _____ Procedure Date _____

Primary Care Physician _____ Height _____ Weight _____

**** **A RESPONSIBLE ADULT/DRIVER MUST REMAIN WITH YOU AT THE ENDOSCOPY CENTER AT ALL TIMES** ****

Please List Below any **Allergies/Sensitivities** to Medication, Materials, Food and Environmental factors and reaction:

Name and Reaction:

- | | | |
|----------|----------|----------|
| 1. _____ | 4. _____ | 7. _____ |
| 2. _____ | 5. _____ | 8. _____ |
| 3. _____ | 6. _____ | 9. _____ |

MEDICATIONS: LIST ALL (PRESCRIPTION, NON PRESCRIPTION, SUPPLEMENTS & VITAMINS)

MEDICATION NAME	DOSE TAKEN	FREQUENCY	REASON TAKEN
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____
9. _____	_____	_____	_____
10. Do you take a blood thinner?	Yes	No	Name: _____

Do you have any of the following? **IF YES, contact your GI physician's office for further evaluation**

Trouble Breathing or Anaphylaxis to Latex or Rubber Products?	Yes	No
Oxygen at Home to Help You Breathe?	Yes	No
A Letter Stating You Are Difficult to Intubate?	Yes	No
An Implanted AICD for Your Heart?	Yes	No
Currently Pregnant or Breast Feeding?	Yes	No
Currently on Dialysis?	Yes	No
Problems with Anesthesia (if so explain)	Yes	No _____

Have You Ever Been Diagnosed With the Following: (Please Circle if You Have Had or Currently Have?)

Congestive Heart Failure	Colon Cancer	Seizures (date of last) _____
Irregular Heart Beats	Cirrhosis	Stroke/TIA/CVA (date of last) _____
Chest Pain/Angina	Liver Disease	Infectious Diseases (type) _____
Heart Attack (Date) _____	Hepatitis(type) _____	Bleeding/Clotting Disorder (type) _____
Heart Stents (number) _____	Colostomy Bag	Cancer(type) _____
Shortness of Breath	Colitis/Crohn's	Chemotherapy or Radiation: Dates _____
Sleep Apnea (CPAP setting) _____	Anemia	Shingles
COPD	C. Difficile	HIV/AIDS
Kidney Failure	Diabetes	High Blood Pressure
Do you Smoke/chew tobacco? _____	If Yes, Please Do NOT smoke/chew on the day of your procedure	
Drink Alcohol? _____ # of drinks/week _____	Other/Misc.: (please list) _____	

Surgeries: Please List All Major Surgeries

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |



Coding Your Procedure

Your procedure will be coded based upon documentation from your physician during the procedure, which may not be covered by your insurance carrier at 100%. If abnormal findings such as a polyp or lesion are detected and removed, the service may then be considered diagnostic by your insurance carrier. Please be aware that you will be responsible for any expenses not covered by your insurance carrier and that the diagnosis code will not be changed in an attempt to reduce out of pocket expenses.

Any questions regarding specific portions of your bill, please call the numbers below:

Physician	Cary Gastroenterology	(919) 816 - 4948
Facility Fees	Raleigh Endoscopy Center	(844) 248 - 1741
Anesthesia	Raleigh Sedation Services	(800) 242 - 5080

Notice of Patient Rights

Cary Gastroenterology provides Notice of Patient Rights to you for both Cary Gastroenterology and Raleigh Endoscopy Centers. These documents can be located at www.carygastro.com. Once you have reached our website, look at the top of the first page and click on the "Prep Resources" link, then scroll down until you see the "General Paperwork" list of options and then click on the "Notice of Privacy Practices".

COLONOSCOPY FREQUENTLY ASKED QUESTIONS

Q: Where is my procedure?

A: Your procedure will be performed at location stated on your prep packet. Please review your prep packet for the location of your procedure. We do not perform procedures in our Cary office, so check the location on your confirmation letter.

Q: When should I read my prep instructions?

A: **NOW!** Please review and become familiar with what you will need to do and call or send your doctors medical team a portal message with any questions.

Q: How long does the procedure take?

A: Done separately, the colonoscopy and EGD procedure are 30 minutes each. If you are having a double procedure (Colon/EGD) done then this can be between 45 and 60 minutes. Patients need to plan on being at the endoscopy center a total of 3 hours. This allows time for intake, procedure and recovery time.

Q: What are the requirements for transportation to and from the endoscopy center?

A: Patients are required to have a driver 18 or older bring them to the endoscopy center, stay with them throughout the duration of the visit and drive them home. This is a patient safety issue and no exceptions will be made for this requirement. Patients cannot drive themselves, take an uber, walk or use a bicycle to get to and from their procedure.

Q: What is the required paperwork for the procedure?

A: Although we gather all health information at the time of scheduling, the Raleigh Endoscopy Center requires that their own forms be filled out which includes the Health History form in your packet. This form must be brought with you to your procedure. Please complete the Health History, Release of Information and Consent forms and bring those with you to your appointment.

Q: When should I pick up my prep?

A: **Today!** We have sent your prescription script electronically to your requested pharmacy. Regardless of when your procedure is scheduled, please pick up your prep as soon as possible. This will help ensure you are prepared in case we may have sooner appointments or you are requesting a sooner procedure. If your insurance is declined to cover the prep we sent over, please reach out to us so we can see about sending an alternative prep. Please keep in mind, Cary Gastro does not know what prep your insurance is going to cover or approve.

Q: What if I need to reschedule my procedure?

A: You need to cancel or reschedule your procedure; we require a 5-business day notice to avoid the \$100 cancelation fee.