EGD INSTRUCTIONS

Procedure Date:_____ Arrival Time_____ Procedure Time: _____

- ☐ 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

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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 EGD 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

CALL CARY GASTROENTEROLOGY IF YOU:

- Require ANTIBIOTICS for invasive procedures
- Have a LATEX ALLERGY
- Are on a blood thinner (Coumadin, Pradaxa, Xarelto, Eliquis, Arixtra, Plavix, Effient)
- Take more than 81mg of ASPIRIN per day.
- **Are on Weight Loss medications and this was not previously disclosed to our scheduling team. All weight loss medications must be stopped 7 days prior to procedure**.

THE FOLLOWING ARE ABSOLUTE REQUIREMENTS FOR YOUR PROCEDURE:

- **A licensed driver is required** (18 or older) to take you to and from your appointment. The driver is required to accompany you at check-in and remain during your test.

- Personally driving, taking a Taxi and or Uber is **strictly prohibited**. Your appointment will be cancelled if you arrive by either of those transportation options. You cannot walk or ride a bike home. Plan on spending 3 hours at the procedure center.

- Wear comfortable clothing. **DO NOT** wear contact lenses. Bring warm socks. Do not bring jewelry or important valuables.

- You should have **NOTHING BY MOUTH** 4 hours prior to your procedure.

IMPORTANT

All medical clearances must be in our office prior to your procedure. If you have a history of cardiac, respiratory or neurological issues and had not disclosed that information to the scheduling team or with the doctor prior to scheduling your procedure, call our office immediately. You may require a medical clearance.

PREP INSTRUCTIONS

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 WEIGHTLOSS MEDICATIONS ADDITIONAL INFO ON PAGE 4.
- **DIABETIC PATIENTS: REVIEW PAGE 4 FOR ADDITIONAL INFO ON 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. If this has not been previously discussed with your doctor, please notify your doctors medical assistant.

THE DAY BEFORE YOUR PROCEDURE: **Day/Date**: _____

- **STOP** all diuretics (water pills) the day before your procedure.
- Start fasting at 11pm the night before your scheduled procedure, no liquids, candies, or anything by mouth.
- Patients specifically taking weight **loss medications (non-diabetic related)**, injectable or pill form, see page **4** for your specific fasting requirements before your procedure.
- **DIABETIC PATIENTS**:
  Review page **4** for specific fasting requirements on certain medications before your procedure.

PROCEDURE DAY:

- **NO FOOD OR LIQUIDS 4 hours before your scheduled procedure time.** Excluding the small sips of water to take your blood pressure or heart medications only.
- Please take your blood pressure or heart medications at your normal time with small sips of water only.

*******IMPORTANT*******

You are to have **NOTHING BY MOUTH** beginning 4 hours prior to your procedure.
This includes clear liquids, breath mints, gum and or candies.
Failure to follow these instructions will result in delay or cancellation of your procedure.

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.

PATIENTS TAKING WEIGHT LOSS MEDICATIONS ONLY
If you are taking any of the medications listed below for weight loss only (non-diabetic related), you will need to start **FASTING at 7AM** the day before your procedure. All weight loss medications must be stopped 7 days prior to your procedure, including injectable and or pill form as indicated on page 3.

DIABETIC PATIENTS ONLY:
If you are taking any of the medications listed below for **diabetes only**, and had not previously divulged that information while scheduling your procedure, notify your gastroenterologists team for further advisement on fasting requirements. If you are on insulin or oral diabetes medications that are not listed below, please consult with your physician to discuss adjusting these medications if you have not already before your procedure.

- 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, please call 919-816-4948 and select option 3

Cary Gastroenterology Associates
UPPER ENDOSCOPY (EGD) CONSENT FORM

Your physician has recommended that you undergo a procedure called an Upper Endoscopy (EGD). An upper endoscopy is a procedure that enables the physician to see the lining of your esophagus, stomach and the part of your intestines called the duodenum. These areas are examined with a lighted flexible tube, slightly smaller than your little finger, called a gastroscope. For the endoscopic examination, the physician may apply a medication to numb your throat. You will be given a sedative injection that will relax you before the tube is inserted. The physician will then insert the flexible tube through your mouth and into your stomach in order to look at the lining of your esophagus, stomach and duodenum. If any abnormalities are detected, the areas will be photographed and biopsies may be taken.

As with any examination, certain risks exist. These include but are not limited to: bleeding, perforation, medication reactions, life threatening events, dental damage and missed lesions. With this procedure a perforation of the esophagus, stomach or duodenum may occur if the flexible tube punctures these organs. A puncture of the stomach or bleeding at the biopsy site may occur from biopsy forceps. Bleeding can be stopped from special instruments. Rarely, blood transfusions and/or surgery may be required in these situations. Some discomfort, such as a sore throat, may also be associated with swallowing the tube. 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**.**

For certain conditions such as a stricture of the esophagus, dilations may be performed. This does carry a small risk of puncture of the esophagus. If a puncture occurs, this may need to be treated with antibiotics, urgent surgery and hospitalization.

If you have any questions or concerns about this procedure, they will be answered for you before you sign this form.

I certify that I have read/been informed 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 _____.

_____ _____

Patient Signature Date

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

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 RESPONISIBLE 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 Breath?	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/Crohns	Chemotherapy or Radiation: Dates_____
Sleep Apnea (CPAP setting) ____	Anemia	Shingles
COPD	C. Difficle	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._____

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.

_____ Date _____

Signature of Patient or Personal Representative

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".

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 cancelation 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