CALVERT DIGESTIVE DISEASE ASSOCIATES
ENDOSCOPY & SURGERY CENTER, LLC

Calvert Digestive Disease Associates
Endoscopy and Surgery Center, LLC

PRE-PROCEDURE INSTRUCTIONS

TO ALL PATIENTS,

YOU MUST fill out all paperwork contained in this packet AND TAKE IT WITH YOU to CDDA on your procedure day.

- This paperwork differs from the paperwork you filled out for our office and is necessary to the nurses and staff at the center to provide you with the very best care at the time of your procedure.
- IF YOU ARRIVE AT THE CENTER WITHOUT YOUR COMPLETED PAPERWORK, YOUR PROCEDURE MAY BE DELAYED.
- Please bring your PHOTO ID and INSURANCE CARDS to the center.
- YOU MUST have a driver at the time of your procedure.
- The driver MUST wait in the waiting room to drive you home as soon as you have been discharged.
- Due to the small size of the waiting room, PLEASE BRING ONLY THE DRIVER into the waiting room area. Thank you for your cooperation.

PLEASE REMEMBER to take medications as indicated by your physician, especially any type of heart medication, prior to your procedure(s).

If you have any questions, please do not hesitate to contact your physician's office.

Thank you for assisting us in these matters!

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PATIENT MEDICAL & SURGICAL HISTORY

What procedure(s) are you scheduled to have done? ❑ Egd ❑ Colonoscopy ❑ Flexible Sigmoidoscopy

Why does your physician want to perform the procedure? _____

Name & Phone number of person taking you home: _____

Please call immediately if you: have an artificial heart valve or joint replacement, pacemaker/ defibrillator or are taking blood thinners (i.e. Coumadin, Plavix, etc.)

List if you are Allergic to: ❑ Medications ❑ Latex ❑ Eggs/Soy

_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING DISORDERS AND GIVE ANY EXPLANATION NECESSARY.

Disorder	Yes	No	Disorder	Yes	No
High Blood Pressure			Back/Neck Problems		
Heart Attack/Angina			Any Joint Replacements		
Congestive Heart Failure			Arthritis		
Heart Murmur/Mitral Valve Prolapse			Seizures/Epilepsy		
Valve Replacement/Cardiac Surgery			Stroke		
Irregular Heartbeat			Glaucoma		
Internal Defibrillator /Pacemaker			Thyroid Problems		
Sleep Apnea			Cancer		
Asthma/Emphysema/COPD			Endocarditis		
Lung Disease/Tuberculosis/Other			Bleeding Disorders		
Diabetes			Reflux (GERD)		
Stomach Ulcer			Reflux Esophagitis		
Liver Disease/Hepatitis/Other			Esophageal Stricture		
Infectious Disease/Other			Hiatal Hernia		
Kidney Disease/Other			Colon Polyps		
Bladder Problems			Diverticulosis/Diverticulitis		
Ulcerative Colitis			Crohn's Disease		
Hemorrhoids			Irritable Bowel/Spastic Colon		
Ostomy			Female only: Are you Pregnant?		
Family History of Colon Cancer			Is English your main language?		

Explanation: _____

Reviewed by MD _____ Date/Time: _____

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PATIENT MEDICAL & SURGICAL HISTORY

SURGICAL HISTORY

Any past surgeries?	❑ Yes	❑ No	If yes, please list:	
Do you have any beliefs or practices that might affect how we teach you (such as religious, cultural or spiritual)?	❑ Yes	❑ No		
Do you have any vision or hearing problems that would interfere with teaching?	❑ Yes	❑ No	How would you prefer to receive information?	❑ Written ❑ Verbal ❑ Demonstration

Height _____ Have you had any problems with intravenous sedation? ❑ Yes ❑ No

Weight _____ Describe: _____

If you are experiencing pain today on a scale of 0-10 (with 0 being no pain and 10 being very severe) how would you define your level of pain?

If pain, describe: _____

Check if you use or have used any of the following:

Alcohol ❑ Yes ❑ No Quantity per day _____

Tobacco ❑ Yes ❑ No Quantity per day _____

Narcotics ❑ Yes ❑ No Quantity per day _____

I.V Drugs ❑ Yes ❑ No Quantity per day _____

Recreational drugs (Marijuana, Cocaine, Heroin) ❑ Yes ❑ No Quantity per day _____

You will be called 24-72 hours post-procedure. If you are unavailable, may we leave a message on your answering machine or with another party at that number? ❑ Yes ❑ No If yes please provide name(s): _____

Do You have Advance Directives, i.e., Living Will, etc., in place now? ❑ Yes ❑ No

(If you currently have an Advance Directive in place, according to Maryland Law, a copy of this is required for your records at CDDA. Please bring a copy with you the day of your appointment.)

Patient Signature _____ Signature of Reviewing RN _____ Date/Time _____

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PATIENT MEDICATION RECONCILIATION

Please list all medications you are currently taking. Include any over the counter medications taken on a regular basis. If you take aspirin, Motrin of any kind, herbals, or vitamins, please list below.

Aspirin, Aspirin Products, and/or Blood Thinners (Coumadin, Plavix, etc.) held for 5 days Pre-procedure: ❑ Yes ❑ No ❑ N/A

Do you have any allergies? ❑ Yes ❑ No If **Yes**, list allergies and describe reaction below

LIST ALL PRESCRIPTION AND NON-PRESCRIPTION (OVER-THE-COUNTER) MEDICATIONS.

Name of Medicine/Herbal, Vitamin	Dose	Route (by mouth, injection, etc.)	Frequency	Reason for taking this medication	Date/Time Last Taken

Patient Signature _____ Signature of Reviewing RN _____ Date/Time _____

❑ Resume pre-procedure medications ❑ Hold Aspirin Products for _____ days

Discharge Medication Changes: _____

_____

_____

_____

Copy to patient at discharge Patient Initials _____ Discharge RN Signature _____ Date/Time _____

If you have any questions about your home medication, please contact your prescribing physician.

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ADVANCE DIRECTIVE

The best person to make decisions about your medical care is you. The best time to make decisions about what kind of medical care you would like, should you become terminally ill, is in advance, while you are healthy and able to make your wishes known.

WHAT IS AN ADVANCE DIRECTIVE?

An advance directive is a written or oral statement that is made and witnessed in advance of serious illness or injury describing your wishes with regard to medical decisions. An advance directive allows you to state your choices about healthcare or to name someone to make those choices for you should you become unable to make decisions about your medical treatment or care.

WHAT IS A LIVING WILL?

A living will generally describes the type of medical care you want or do not want if you are unable to make your own decisions. It is called a living will because it takes effect while you are still living. You may wish to speak to an attorney or physician to be certain you have completed the living will in a way that your wishes will be understood.

WHAT IS A HEALTHCARE SURROGATE DESIGNATION?

A healthcare surrogate designation is a signed, dated and witnessed document naming another person such as a spouse, child or close friend as your agent to make medical decisions for you should you become unable to make them for yourself. This designation is often included in the living will.

You may wish to name a second person as an alternate, should your first choice for healthcare surrogate not be available. Be sure, however, to notify these persons that you have named them as healthcare surrogates, and inform them of your wishes. It is also a good idea to give them, as well as your physician and attorney, a copy of both your living will and the healthcare surrogate designation documents.

DO I HAVE TO COMPLETE AN ADVANCE DIRECTIVE UNDER (STATE) LAW?

No, there is no legal requirement to complete an advance directive. However, if you have not completed an advance directive or designated a healthcare surrogate, healthcare decisions may be made for you by a court appointed guardian, your spouse, your adult child, your parent, your adult sibling, and adult relative or a close friend, in that order.

What if I change my mind after I have completed a Living Will and/or designated a Healthcare Surrogate?

You can change or cancel these documents at any time, either orally, or in writing.

WHAT SHOULD I DO WITH MY ADVANCE DIRECTIVE?

- Make sure that someone, such as your physician, lawyer or family member knows that you have an advance directive and where it is located.
- If you have designated a healthcare surrogate, give that person a copy or the original.
- **Give your physician and any other health care provider a copy for your medical file.**
- Keep a copy of your advance directive in a place where it can be found easily.
- Keep a card or note in your wallet or purse that states that you have an advance directive and where it is located.
- If you change your advance directive, make sure your physician, lawyer and/or family member has the latest copy.

OUR POLICY ON ADVANCE DIRECTIVE

CDDA physicians and staff acknowledge your right to have an Advance Directive and will add it to your medical record. However, in the unlikely event of deterioration of a patient while he or she is in our Center, it is our policy to stabilize that patient and transport him/her to the closest Medicare-participating, Joint Commission-accredited hospital with a copy of the Advance Directive if made available to us. More information regarding Advance Directives in Maryland is available at http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3289.