Perry L. Kamel, M.D.
737 North Michigan Avenue, Suite 620
Chicago, Illinois 60611
Fax: 312.573.9636
312.573.9626

FLEXIBLE SIGMOIDOSCOPY INSTRUCTIONS

APPOINTMENT DATE: _____ APPROXIMATE START TIME: _____

Location and Check-In:
The GI lab is located at 259 E. Erie, Suite 1600, Chicago, IL 60611, Lavin Pavilion. Take the elevators to the 16th floor. **Check in for your procedure at least 30 minutes before your approximate start time. Expect to stay in the GI lab for at least one hour if you are not receiving sedation.**

Parking:
Parking is available in the Lavin Pavilion and can be accessed from either Erie Street or Ontario Street. **Be sure to bring your parking ticket with you to be validated.**

Flexible Sigmoidoscopy:
Flexible Sigmoidoscopy is an examination that enables Dr. Kamel to view the lining of the lower third of the colon. A sigmoidoscope is a thin flexible tube with a tiny video camera on the end. The sigmoidoscope is inserted through the anus into the lower colon.

Sigmoidoscopy is commonly used to evaluate constipation, diarrhea, bleeding, or any unexplained change in bowel habits. Sigmoidoscopy is more accurate than X-rays for diagnosing inflammation, growths and potential sources of bleeding.

Complications with sigmoidoscopy are extremely rare.

Complete the GI Lab Patient Questionnaire and GI Laboratory At-Home Medications List forms and bring them with you to the GI Lab on the day of your sigmoidoscopy.

Inform Dr. Kamel if you are on any of the following medications: **anticoagulants (blood thinners), insulin or oral diabetes medications approximately one week prior to your scheduled procedure.** The dosage of these medications will need to be adjusted or discontinued. Your other medications can be continued. On the day of your sigmoidoscopy, take all of your routine medications. Tylenol or acetaminophen is perfectly safe to take prior to your procedure.

Flexible SigmoidoscopyPreparation:

You will need to purchase 4 Fleet Enemas® (generic equivalent is fine), which are 4½ ounce, squeeze bottle type enemas, in a green box that are available over the counter at pharmacies.

Begin your bowel preparation approximately 1 hour before leaving your home. There are no dietary restrictions prior to the sigmoidoscopy.

- Lie on your left side with your knees to your chest.
- Remove the enema cap and gently slide the lubricated enema tip through the anus pointing up toward your belly button.
- Gently, but firmly, squeeze the contents of the enema into the rectum and then withdraw the enema tip.

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FLEXIBLE SIGMOIDOSCOPY INSTRUCTIONS (Cont'd.)

- Hold the liquid as long as possible--3 to 5 minutes is typical. Then use the washroom.
- Repeat this process with the 2nd and 3rd enemas.
- If the output is clear, you do not need to use the 4th enema.
- If you see stool after the 3rd enema, use the 4th enema.

During the Flexible Sigmoidoscopy:

Dr. Kamel will explain the sigmoidoscopy and answer any question you may have. You will be asked to lie on your left side while covered with a sheet on an examining table. Dr. Kamel will initially do a rectal examination. The sigmoidoscope will then be inserted into your rectum and slowly advanced through the lower colon. If there are any abnormalities, a biopsy will be obtained which does not cause pain. The sigmoidoscopy usually lasts 5 to 10 minutes. Any discomfort usually comes as a bloated feeling when air is added to the colon to allow for better viewing or as cramping when the sigmoidoscope is advanced around curves of the colon. The sigmoidoscopy is well tolerated.

After the Flexible Sigmoidoscopy:

Immediately after the sigmoidoscopy, you may experience mild cramping or bloating from the air that was added to the colon. The cramping and bloating will resolve with the passage of gas. You will be able to go about your normal routine after you leave the GI Lab. Dr. Kamel will inform you of your test results after the examination is completed. If biopsy samples are taken, the results will be available in several days and Dr. Kamel will discuss them with you by phone. After leaving the GI Lab, it is important for you to recognize symptoms that need to be reported. These symptoms are severe abdominal pain, fever (above 100.5°), chills, or significant rectal bleeding. Some scant bleeding may occur if biopsies are done. You will receive discharge instructions.

You may call Dr. Kamel if you have any questions or concerns after leaving the GI Lab, either at the office 312.573.2457, or at 312.649.2952 after office hours.

If you opt to receive intravenous sedation, please carefully read the Northwestern Memorial Hospital "General Instructions for Patients Undergoing GI Lab Procedures." No solid food for 6 hours prior to your approximate start time. You may have clear liquids up to 4 hours prior to your approximate start time.

Northwestern Medicine®

GI LAB PATIENT QUESTIONNAIRE

Refer to Reminder below before completing this form. Thank you for choosing Northwestern Memorial Hospital for your GI Lab procedure. **Please fill out this form and bring it with you the day of the procedure.** Please answer each question. This allows us to provide you with the best possible care.
(Please print)

Patient Name _____ **Date of Birth** _____ **Date of Procedure** _____

Name of Primary Care Physician _____ **Fax Number** _____

Address _____ **Phone Number** _____

Procedure and Related Information: *** Procedure normally requires sedation**

- ☐ Flexible Sigmoidoscopy
- ☐ Colonoscopy*
- ☐ Upper Endoscopy (EGD)*
- ☐ Endoscopic Ultrasound/Fine Needle Aspiration*
- ☐ ERCP*
- ☐ Liver Biopsy*
- ☐ Esophageal/Rectal/Small Bowel Manometry
- ☐ 24-hour Ambulatory pH Study
- ☐ Other _____

Reason for visit? _____

Please list the date of your last colonoscopy _____ (Month) _____ (Year)

Please list the date of your last upper endoscopy (EGD) _____

When was the last time you ate solid food? Date _____ Time _____

When was the last time you drank liquid? Date _____ Time _____

If your test required a bowel preparation, what preparation did you take? _____

Did you complete the preparation? ☐ Yes ☐ No–how much did you complete? _____

On the day of your procedure, will you have any of the following: *(Please circle)* Dentures, Removable Bridgework, Glasses, Hearing Aide, Walker, Cane, Wheelchair, Prosthetics, Other _____

Family/Friends/Transportation:

Who will be waiting for you during the procedure and/or taking you home afterwards?

Name _____ Relationship _____

Daytime contact number(s) _____

Verified by Admitting Nurse _____ Date _____ Time _____

Reminder: Per NMH Policy, after receiving any amount of sedation, you MUST have a responsible adult accompany you home after your procedure. You will not be discharged for any reason without an escort.

- If the admitting staff cannot verify your ride home, your procedure will be cancelled.
- You may not walk or take a cab/Uber/CTA home.
- You may not leave the GI Lab unaccompanied for any other appointments you have within NMH.

If your home is within the set service area of Superior Ambulance Company, you may make arrangements for them to take you home for an additional fee (contact Superior for pricing). If you would like to arrange this service, please call 312.926.5988 to make arrangements. Payment will be required at the time of service.

→ Complete both sides of form

Do you take?

YES	NO		YES	NO	
☐	☐	Sleeping or Anti-anxiety Medications, Sedatives	☐	☐	Prescribed Anticoagulants, Blood Thinners
					Last Dose Taken (Date _____ Time _____)
☐	☐	Aspirin or Non-steroidal Anti-inflammatory Drugs	☐	☐	Insulin or pills to control your blood sugar

Past/Present History:

YES	NO	
☐	☐	Are you currently experiencing pain? _____
		Is your pain chronic? _____ Location _____
		Please rate your pain – 0 (no pain) to 10 (worst pain) _____
☐	☐	Have you or has anyone in your family ever had reactions to the medications given to you during any procedures or surgery? _____
		Please describe _____
☐	☐	Allergies (such as drug, food, latex): Please list _____
		Reaction _____
☐	☐	Have you experienced a fall in the last 12 months? Please describe _____
☐	☐	Have you ever fainted, felt dizzy or nauseous after having your blood drawn or an IV started?
☐	☐	Diabetes: If yes, do you take insulin or pills? _____
☐	☐	Did you take your blood sugar level the day of your procedure? _____
		Time taken and results _____
☐	☐	High blood pressure: Is your blood pressure controlled by medication? _____
☐	☐	Do you take antibiotics prior to medical or dental procedures? Antibiotic and dose _____
☐	☐	Heart problems _____
☐	☐	Heart pacemaker, implanted cardiac defibrillator _____
☐	☐	Lung disease: (such as Asthma, Emphysema) _____
☐	☐	Sleep apnea _____
☐	☐	Cancer – Location _____
☐	☐	Kidney disease _____
☐	☐	Neurological problems: (such as seizures) _____
☐	☐	Gastrointestinal disease or symptoms: (such as reflux, Crohn's Disease, ulcerative colitis) _____
☐	☐	Liver disease: (such as cirrhosis, hepatitis) _____
☐	☐	Glaucoma _____
☐	☐	I smoke/use tobacco products. If NO: Do you have a history of use? (circle one) YES / NO
		If YES or HISTORY: Amount per day _____ For how many years _____
☐	☐	Alcohol/substance use: How much per day? _____ Last drink _____
☐	☐	Have you had a hysterectomy? _____
		For women ages 12–50, when was the first day of your last menstrual period? _____
☐	☐	Are you pregnant or trying to become pregnant? _____
☐	☐	Is there a possibility that you might be pregnant? _____
☐	☐	Other (such as arthritis, blood disorders, HIV, infectious diseases, breast feeding) _____
☐	☐	Do you follow a special diet for medical reasons? (For example, gluten-free) _____

Please list your surgeries _____

_____

Patient Signature _____ **Date** _____ **Time** _____

Signature of Admitting Nurse _____ **Date** _____ **Time** _____

Reviewed by Physician Signature _____ **Date** _____ **Time** _____

Northwestern Medicine®
Northwestern Memorial Hospital

GI LABORATORY
At-Home Medications List

Dear Patient,
Please complete the Allergies and Medication sections. A staff member will review this list with you and update if necessary.
If you have questions about medications NOT prescribed during today's visit, please contact your primary care physician.

ALLERGIES: ☐ None (check the box if you do not have any allergies) Date_____

Source	Reaction	Source	Reaction
Example: Penicillin	*Hives*	*3.*	
1.		*4.*	
2.		*5.*	

MEDICATIONS: ☐ None (check the box if you do not take any medications, vitamins, herbals, etc.)

DRUG List the name and strength of the medications you are taking. Include all over-the-counter medicines, vitamins, herbals, minerals, and those you may have held for today's visit.	**DOSE FORM** How many tablets, units, capsules, are you taking at one time?	**FREQUENCY** How often do you take the medication? (Once a day, twice a day, etc.)	**ROUTE** How are you taking this medication? (By mouth, injection, patch, etc.)	**LAST DOSE TAKEN** Indicate the date and time you last took the medication.
Example: Cardizem CD	*1 capsule*	*Once a day*	*By mouth*	*9 pm last night*

Patient's Signature _____ Staff Signature _____

Do not write below this line – Hospital Staff ONLY

INSTRUCTIONS:
Staff: Provide the patient with a photocopy of this document if a long-term medication was added, changed, or discontinued for the at-home regimen during this visit. You may also provide a photocopy if *any* medication addition, change, or discontinuation was made. After completing the patient instructions portion below, instruct the patient regarding changes, provide the photocopy to the patient, check the box below, and file the original in the patient's medical record.

☐ Medication instructions were reviewed with the patient. The patient received a photocopy of this medication list.

Patient: START/RE-START taking this at-home medication(s):

Condition Medication is prescribed for:	At this Dose/Dose Form:	How often: (Frequency)	Route:	**Start** taking this Medication on:	Date, if any, you should **stop** taking this medication:
				____ /____ /_____	
				____ /____ /_____	
				____ /____ /_____	
				____ /____ /_____	

Patient: STOP taking this at-home medication:

STOP taking this medication (include drug name, strength, dose form, frequency): _____

You should stop taking it on: _____ / _____ / _____

Additional Comments: _____

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FINANCIAL POLICY

Your insurance statement consists of two parts--a patient portion and an insurance portion. When an insurance company is responsible for medical services, you are responsible only for the patient portion. However, when an insurance carrier delays, or withholds payment, both the insurance and the patient portion become your responsibility.

In the absence of insurance carrier payment, our office policy is to bill your credit card for payment in full. We will do our best to work with all insurance carriers.

When your account has gone beyond a 90-day limit, it is extremely important that you speak with your insurance carrier concerning payment. If the insurance carrier eventually pays for medical services, we will refund the charges we have made on your credit card.

Send To: Perry L. Kamel, M.D., S.C.
737 North Michigan Avenue
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Credit Card Information (please print):

Name of Card Holder:_____ _____ ____
Last First MI

Name of Patient: _____ _____ ____
Last First MI

Name of Card: ____ VISA ___ MASTERCARD ___ DISCOVER ___ AMERICAN EXPRESS

Card Number: _____

Expiration Date: Month (00) _____ 20_____

Authorized Signature: _____

Home Billing Address: _____

Billing Address (if different): _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

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PERRY L. KAMEL, M.D., S.C., FINANCIAL POLICY

ILLINOIS STATE LAW requires insurance carriers to pay claims within 30 days of receipt. Many insurance carriers have been very slow in reimbursing physicians for medical services and are therefore not in compliance with these regulations.

Perry L. Kamel, M.D., S.C., has instituted a policy addressing unpaid charges which have been submitted to your carrier. If your account is three (3) months or more past due, it may become your responsibility to pay the remaining portion, which will appear on your patient account statement. We will contact you prior to making a charge to your personal credit card for outstanding balances beyond three months. If your insurance company forwards payment after you have paid your balance, we will gladly credit your account.

We suggest that you monitor your personal account with us very closely and follow the balance as it ages beyond thirty days, at which time you should call your insurance company and request a "claim status report".

- Keep in mind the following points when speaking with the insurance claim manager:
- Identify the date of service for the unpaid claim
- Record and retain the date that you called the insurance company
- Record and retain the name of contact with the insurance company
- Identify and correct the problem causing payment delay
- Verify that the insurance company has the appropriate billing information including:

  – Full name of insured
  – Full address of insured
  – Guarantors name of policy
  – Social security number for the guarantor
  – Correct billing address for your policy
  – Insurance policy number

Ask the claims manager when you can reasonably expect a reimbursement and correction of the problem.

Follow up periodically with the same person to ensure activity occurs on your personal account.

Please complete the credit card information sheet in order to ensure proper continuity of care within our practice. When your insurance carrier is holding or denying payment for medical services rendered, it is best if you call them directly with your concerns and questions.

Whether or not you have insurance or are self-pay, payment of any account balance is due within thirty (30) days of receipt of your billing statement. If any balance on your account is over ninety (90) days past due, your account will be in default and referred to a collection agency. In the event of default, the patient will be responsible for costs of collection and attorney's fees. Payments can be made by phone or mail. We are working on online payments at this time.