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**COLONOSCOPY INSTRUCTIONS FOR OSMO PREP™ BOWEL PREPARATION**

**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 45 minutes before your approximate start time. Expect to stay in the GI lab for at least three hours.**

**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.**

**Colonoscopy:**

Colonoscopy is an examination that enables Dr. Kamel to view the lining of the rectum and colon. A colonoscope is a thin flexible tube with a tiny video camera on the end. Complications with colonoscopy are very uncommon. One possible complication of polyp removal is severe bleeding. A tear in the lining of the colon may occur. Both of these complications require hospitalization and, possibly, surgery. Please discuss possible complications with Dr. Kamel.

**Preparing for Colonoscopy:**

Inform Dr. Kamel if you have an **ICD (implantable cardioverter defibrillator)** and 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 colonoscopy, take all of your routine medications with sips of water. Tylenol or acetaminophen is perfectly safe to take prior to your colonoscopy.

**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 colonoscopy.

**Diet:** Seven days prior to your colonoscopy, stop eating all seeds, nuts and corn.

**Clear Liquid Diet:** *The following diet should be taken for the entire day before--not just 24 hours prior to your exam--and continued up to 2 hours prior to your colonoscopy:* water, coffee/tea (a small amount of cream or milk is allowed), soft drinks, clear fruit juices (such as white cranberry juice, white grape juice, apple and lemonade), Jello® (with no solid fruit in it), popsicles, broth or bouillon. No red or purple.

**DO NOT EAT OR DRINK ANYTHING DURING THE 2 HOURS PRIOR TO YOUR COLONOSCOPY, INCLUDING SUCKING ON CANDY OR CHEWING GUM.**

**Taking the Osmo Prep™ Tablets:**

The evening before your colonoscopy, 20 of the Osmo Prep™ tablets will be taken over a 1-hour time period. **Starting at 5 p.m. (you can start earlier or later than 5 p.m.),** take 4 Osmo Prep™ tablets every 15 minutes with at least 1 glass (8 ounces) of clear liquids (water, any clear carbonated drink or

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**First 20 Osmo Prep™ Tablets:**

clear juice). **It is very important to drink at least 8 ounces of clear liquid when taking the Osmo Prep™ tablets to prevent excessive fluid loss or dehydration.** Do not exceed 20 Osmo Prep™ tablets. You will begin having bowel movements within 1 to 2 hours after finishing the 20 Osmo Prep™ tablets.

<u>Dose 1</u>	<u>5:00 p.m.</u>	4 tablets with 8 ounces of clear liquids
<u>Dose 2</u>	<u>5:15 p.m.</u>	4 tablets with 8 ounces of clear liquids
<u>Dose 3</u>	<u>5:30 p.m.</u>	4 tablets with 8 ounces of clear liquids
<u>Dose 4</u>	<u>5:45 p.m.</u>	4 tablets with 8 ounces of clear liquids
<u>Dose 5</u>	<u>6:00 p.m.</u>	4 tablets with 8 ounces of clear liquids

*\*Follow-up the last dose of tablets with an additional 12 ounces of clear liquids.*

**Last 12 Osmo Prep™ Tablets:** On the **day of your colonoscopy**, the last 12 Osmo Prep™ tablets will be taken over a 30 minute period. At least 3 hours before leaving home, **take 4 Osmo Prep™ tablets every 15 minutes with at least 1 glass (8 ounces) of clear liquids (water, any clear carbonated drink or clear juice).** **It is very important to drink at least 8 ounces of clear liquid when taking the Osmo Prep™ tablets to prevent excessive fluid loss or dehydration.**

<u>Dose 1 (Take at least 3 hours before leaving home)</u>	_____ a.m.	4 tablets with 8 ounces of clear liquids
<u>Dose 2 (Take 15 minutes after Dose 1)</u>	_____ a.m.	4 tablets with 8 ounces of clear liquids
<u>Dose 3 (Take 15 minutes after Dose 2)</u>	_____ a.m.	4 tablets with 8 ounces of clear liquids

*\*Follow-up the last dose of tablets with an additional 12 ounces of clear liquids.*

**If you cannot tolerate the Osmo Prep™ tablets, or if you are not passing clear yellow liquid after completing the 32 tablets, call Dr. Kamel's office at 312.573.2457, or his answering service after hours at 312.649.2952, to speak to Dr. Kamel.**

**During the Colonoscopy:**

Dr. Kamel will explain the examination and answer any questions you may have. You will be given pain and sedative medications through an IV to keep you comfortable. The colonoscope will be inserted into your rectum and gently advanced through the colon. The colonoscopy procedure usually lasts 30 minutes and is well tolerated. Any discomfort that takes place usually comes as a bloating feeling when the physician adds air into the colon to expand the folds of the colonic tissue for easier viewing, or a cramping feeling when the colonoscope is advanced around the curves of the large intestine.

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**After the Colonoscopy:**

You will be monitored after the procedure in the recovery area for a minimum of 1 hour. Dr. Kamel will discuss your test results with you. Biopsy results take several days to return, and Dr. Kamel will discuss them with you by telephone. **You absolutely cannot drive until the following day, and an adult must accompany you home. You may not walk, take a taxi or any public transportation home unless you are accompanied by a responsible adult.**

If you do not have an adult to accompany you home, you can arrange a ride home with **Illinois Medi Car through Superior Ambulance Company** by calling **312.926.5988**. Hours of Operation are Monday through Friday 7 a.m. to 7 p.m. Arrangements should be made before the day of your procedure but they can be made the day of the procedure. At times, Illinois Medi Car will take two patients home at the same time with the same Medi Car, however, this does not happen frequently.

Illinois Medi Car rates are **\$25 as a flat rate just to take the service.** A **\$2.50 per mile will be charged in addition to the \$25 flat rate for every mile travelled.** Payment is required at the time of service with cash or credit card. Any questions or concerns about a bill from Illinois Medi Car can be directed to Celeste Basom at 630.854.1364.

• **Service area:**

- North – 5600 Bryn Mawr Avenue
- West – 2400 Western Avenue
- South – 47<sup>th</sup> Street

If you have made Illinois Medi Car arrangements for your discharge home, please inform the GI Lab staff on the day of your procedure.

You may do light activity for the remainder of the day. It is important for you to recognize signs and symptoms that should be reported to your physician, which are: severe abdominal pain, fever (above 100.5°), chills or severe rectal bleeding. Some scant bleeding may occur. Please be aware you will receive written discharge instructions before leaving the GI Lab.

**You can speak to Dr. Kamel if you have any questions or concerns after returning home, either at the office 312.573.2457, or after hours at 312.649.2952.**

## 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**

- |  |  |
|--|--|
| <input type="checkbox"/> Flexible Sigmoidoscopy                        | <input type="checkbox"/> ERCP*                                   |
| <input type="checkbox"/> Colonoscopy*                                  | <input type="checkbox"/> Liver Biopsy*                           |
| <input type="checkbox"/> Upper Endoscopy (EGD)*                        | <input type="checkbox"/> Esophageal/Rectal/Small Bowel Manometry |
| <input type="checkbox"/> Endoscopic Ultrasound/Fine Needle Aspiration* | <input type="checkbox"/> 24-hour Ambulatory pH Study             |
| <input type="checkbox"/> 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.

**Do you take?**

**YES NO**

- Sleeping or Anti-anxiety Medications, Sedatives
- Aspirin or Non-steroidal Anti-inflammatory Drugs

**YES NO**

- Prescribed Anticoagulants, Blood Thinners  
Last Dose Taken (Date \_\_\_\_\_ Time \_\_\_\_\_ )
- 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 \_\_\_\_\_

