Perry L. Kamel, M.D.
737 North Michigan Avenue, Suite 620
Chicago, Illinois 60611
Fax: 312.573.9636
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SUTAB TABLETS COLONOSCOPY 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 60 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 SUTAB TABLETS Solution Starting Day Before Colonoscopy:

- **Complete Steps 1-4 using (1) 12 tablet bottle starting in the late afternoon.**
- **The SUTAB TABLETS solution will cause diarrhea for at least 3 to 4 hours.**
- **You may continue drinking clear liquids until you go to bed.**

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4:OOpm-5:OOPM The evening before your procedure:

DOSE 1—On the Day Prior to Colonoscopy

Take the tablets with water

STEP 1 Open 1 bottle of 12 tablets.

STEP 2 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 of water over 15 to 20 minutes.

Tablets not shown actual size.

IMPORTANT: If you experience preparation-related symptoms (for example, nausea, bloating, or cramping), pause or slow the rate of drinking the additional water until your symptoms diminish.

Drink additional water

STEP 3 Approximately 1 hour after the last tablet is ingested, fill the provided container again with 16 ounces of water (up to the fill line), and drink the entire amount over 30 minutes.

STEP 4 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.

Approximately 5 hours before your procedure:

DOSE 2—Day of the Colonoscopy

- Continue to consume only clear liquids until after the colonoscopy.
- The morning of colonoscopy ***(5 Hours)*** prior to the colonoscopy and no sooner than 4 hours from starting Dose 1), open the second bottle of 12 tablets.
- Repeat STEP 1 to STEP 4 from Dose 1.

Tablets not shown actual size.

IMPORTANT: You must complete all SUTAB tablets and required water at least 2 hours before Colonoscopy.

Day of the Colonoscopy:

Repeat and Complete Steps 1-4 using (1) 12 tablet bottle starting in the late afternoon. 5 Hours before your procedure.

Be sure to complete ALL 4 Steps on this dose.

Once you are finished with the 2nd dose of the prep, NOTHING BY MOUTH during the 2 hours prior to the procedure, including sucking on candy or chewing gum.

If you cannot tolerate the SUTAB TABLETS, or if you are not passing clear yellow liquid after completing the SUTAB 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 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 – 47th 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.

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** _____

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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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