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

UPPER ENDOSCOPY 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 4th floor. **Check in for your procedure at least 1 hour before your approximate start time. Expect to stay in the GI lab for at least three hours.**

Parking:
Parking is available across the street from the hospital at the parking garage with entrances on Huron and Superior. **Be sure to bring your parking ticket with you to be validated.**

Upper Endoscopy:

Upper Endoscopy is an examination that enables Dr. Kamel to view the lining of the esophagus, stomach and duodenum (beginning of the small intestine). A flexible endoscope is used to perform the examination, which is a thin tube with a tiny video camera at the tip. The endoscope is introduced into the mouth and then gently advanced down the esophagus, stomach and then into the duodenum.

Upper Endoscopy is helpful to evaluate upper abdominal pain, nausea and vomiting, heartburn, bleeding and swallowing problems. Endoscopy is more accurate than X-rays for identifying abnormalities of the upper intestinal tract. A biopsy, a small piece of tissue, may also be taken to evaluate any observed abnormality, which is not painful.

Complications with Upper Endoscopy 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 upper endoscopy.

Preparing for Upper Endoscopy:

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 Upper Endoscopy, take all of your routine medications with sips of water. Tylenol or acetaminophen is perfectly safe to take prior to your Upper Endoscopy.

DO NOT EAT SOLID FOOD FOR 6 HOURS PRIOR TO YOUR PROCEDURE OR AFTER MIDNIGHT IF YOUR UPPER ENDOSCOPY IS SCHEDULED FOR THE EARLY MORNING.

YOU MAY HAVE CLEAR LIQUIDS UP TO 2 HOURS BEFORE YOUR UPPER ENDOSCOPY:
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. **DO NOT TAKE ANYTHING BY MOUTH DURING THE 2 HOURS PRECEDING YOUR TEST OTHER THAN MEDICATIONS WITH SIPS OF WATER, INCLUDING SUCKING ON CANDY OR CHEWING GUM.**

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UPPER ENDOSCOPY INSTRUCTIONS (Cont'd.)

During the Upper Endoscopy:

Dr. Kamel will explain the procedure and answer all your questions prior to the endoscopy. You will be given pain and sedative medication through an IV to keep you comfortable during the procedure. Throughout the examination, your blood pressure, heart/respiratory rate, and oxygen level will be monitored. You will be on your left side in a comfortable position as the endoscope is gently passed through your mouth and into the upper gastrointestinal tract. The endoscope will not interfere with your breathing and you may feel a mild pressure in your stomach. The examination usually lasts 15 to 20 minutes, and you will be very comfortable.

After the Upper Endoscopy:

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 10 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 for the first 10 miles, as a flat rate. Beyond 10 miles, $2.50 per mile will be charged in addition to the $25. Any questions or concerns about a bill from Illinois Medi Car can be directed to Celeste Basom at 630.854.1364.

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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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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