

Perry L. Kamel, M.D.
259 East Erie Street, Suite 1600
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 16th 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:

Northwestern Memorial's main parking structure is located at the Huron/Saint Clair parking garage, 222 East Huron Street (Parking Garage A). Additional parking is available at 259 East Erie Street, Lavin Pavilion (Parking Garage C) and can be accessed via Ontario Street and 321 East Erie Street (Erie/Ontario Parking Garage D). **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: **blood thinners (i.e. Coumadin (warfarin), Plavix, Pradaxa, Xarelto, Eliquis, Savaysa, Bevyxxa, Lixiana), 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.**

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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.

IMPORTANT INFORMATION FROM NORTHWESTERN HOSPITAL

Please plan to be in our department for 3 to 3-1/2 hours starting at your arrival time (not procedure time). For your own safety post-sedation, you will need a ride home from a responsible adult. Please make transportation arrangements for a responsible adult to pick you up and accompany you back to your home once discharged. You cannot take a Taxi, Rideshare (Uber, Lyft, etc.) or public transportation by yourself. Your procedure will be canceled if we cannot get in contact with your ride during admitting processes. Please be sure your ride is prepared to answer our phone call. Your ride will receive an additional call 1 hour prior to your estimated discharge time. Please ensure your ride anticipates receiving this call around 2 to 2-1/2 hours after arrival time. Your ride must present to our department to pick you up. Our staff is not able to escort you to the lobby or parking garage to meet your ride.

If your home is within the set service area, and 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**. (Contact them for pricing.) Payment will be required at the time of service. Hours of Operation are Monday through Friday 7 a.m. to 10 p.m. Arrangements should be made as soon as possible before the day of your procedure to assure that a Medi Car is available on the day of your 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.

• Service area:

- o North – 5600 Bryn Mawr Avenue
- o West – 2400 Western Avenue
- o 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.

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 _____

**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 |
|----------------------------|--------------|--------|----------|
| <i>Example: Penicillin</i> | <i>Hives</i> | 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. |
|--|--|---|--|--|
| <i>Example: Cardizem CD</i> | <i>1 capsule</i> | <i>Once a day</i> | <i>By mouth</i> | <i>9 pm last night</i> |
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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
Suite 620
Chicago, IL 60611

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.