



ST. JOSEPH HOSPITAL

Issued Date: _____

***This prep replaces any previous prep instructions that you may have received.**

Colonoscopy Instructions NuLYTELY

Date: _____ Arrival Time: _____ Dr. _____

**You may be contacted by the Endoscopy Department the day of your procedure to adjust your arrival time.*

Location: 172 Kinsley Street, Nashua, NH – Main Lobby, 2nd Floor Endoscopy Department

Pre-registration is required one week prior to your procedure. To register or if you have any questions about cost of coverage, please call **866-620-4781**.

If you have any questions regarding your prep or procedure or, if for any reason you need to reschedule your procedure, **please call 603-578-9363**.

PLEASE BE SURE TO REVIEW “IMPORTANT INSURANCE INFORMATION” AT THE END OF THE PACKET.

Colonoscopy Checklist

- **If you had a colonoscopy in the past with an inadequate prep, call our office as soon as possible since your prep may change.**
- **If you have a history of congestive heart failure, or a history of any other cardiac conditions, please call your cardiologist or managing physician to determine if you need cardiac testing or a follow up visit prior to your procedure.**
- **Due to the anesthesia that will be administered during your procedure, it is required that you have a responsible adult or person of legal driving age to drive you home after your procedure. You cannot drive or walk. You cannot take a taxi/Uber unless you are accompanied by a responsible adult. We fully expect you will be able to return to your normal activities the day after your procedure.**
- **If you need assistance with transportation:**
 - Some insurance carriers provide assistance with medical ride services. Please call your insurance company to check availability.
 - In addition, Gentle Care Ride offers medical transportation for a fee and services most of the Southern and Central NH region. They can be reached by calling 603-341-1720 (they require at least two days’ notice; however, please call early due to availability).

IMPORTANT: PLEASE READ ALL MATERIAL



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Medications

PLEASE CALL YOUR MANAGING OR PRESCRIBING PHYSICIAN IF:

- You take blood thinners such as Coumadin (Warfarin), Apixaban (Eliquis), Plavix (Clopidogrel), Aggrenox, Ticlid (Ticlopidine), Pradaxa (Dabigatran), Effient (Prasugrel), Brilinta (Ticagrelor) or Xarelto for instructions on stopping these.
- You have Diabetes, to discuss your diabetes medications.
- You are receiving Lovenox injections. These must be stopped 24 hours prior to your procedure.
- For questions on all other medications, please consult your managing or prescribing physician

GI CANNOT ADVISE YOU ON THE ADJUSTMENT OF YOUR MEDICATIONS. PLEASE CALL YOUR MANAGING OR PRESCRIBING PHYSICIAN IF YOU HAVE QUESTIONS ABOUT YOUR PRESCRIBED MEDICATIONS.

Colonoscopy Preparation

7 Days Prior

- Confirm you have a responsible adult to drive you home. **You cannot drive** or walk. You **cannot** take a taxi, Uber or other ride service unless you are accompanied by a responsible adult. Please see first page if you need transportation assistance.
- Stop oral iron supplements (not infusions), multivitamin w/iron, fish oil, vitamin E.
- **Begin a Low-Fiber diet: avoid any foods with seeds, peels, nuts, salads, and raw vegetables. See below. See below for examples.**

ALLOWED	AVOID
Meats (beef, pork, poultry-without skin) and fish	Whole wheat or whole-grain breads, cereals or pastas
White bread without seeds or nuts	Brown or wild rice, oats, kasha, barley, quinoa
White rice, White pasta, crackers	Dried fruits and prune juice
Pancakes and waffles	Fruits with seeds, skins, or membranes (grapes, oranges, berries)
Cooked and peeled carrots, potatoes, seedless squash, veggie noodles without skins	Raw or undercooked vegetables and salads (corn, lettuce, brussels sprouts, spinach)
Fruits without skins, seeds, or membranes (melons, bananas, peeled apples, peeled canned fruits)	Beans, peas, and lentils
Milk and foods made from milk, milk substitutes	Seeds and nuts, and foods containing them (peanut butter and other nut butters)
Butter margarine, oils and salad dressings without seeds	Popcorn

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3 Days Prior

- Please complete the enclosed health history form at the end of the packet and bring with you the day of the procedure.
- Purchase 1-NuLYTELY prescription (this will be electronically sent to your preferred pharmacy). *This will be accompanied by disposable 128 oz. bottle.*
- Preferred clear liquid to mix with NuLyteLy powder. DO NOT use RED, ORANGE, or PURPLE colored liquids.

Day Before Procedure

LIGHT Breakfast: Before 9AM

- Examples to choose from:
 - 2 eggs any style, 2 slices of white bread
 - 1 plain bagel with butter, jelly, or cream cheese
 - 1 cup of yogurt
 - 1 banana
 - Coffee/tea as desired

After 10AM - NO SOLID FOOD OR FULL LIQUIDS – ONLY CLEAR LIQUIDS. NO ALCOHOL, MILK/MILK PRODUCTS, ORANGE JUICE, CHALKY ANTACIDS. *

***Clear Liquids Include** – Apple Juice, white grape juice, Gatorade, PowerAde, Kool-Aid, Crystal Light, fruit flavored water. Clear soda (regular or diet), clear broth, bouillon, popsicles, Jell-O (not red), coffee/tea (NO milk/cream). **Please make sure all clear liquids are not red/orange/purple in color.** Please avoid all smoothies and shakes as these are considered full liquids.

Starting at 5PM

- Mix the entire packet of NuLYTLELY powder into jug provided as directed by prescription (cold liquid is recommended):
- Drink ½ of the mixture no faster than 8oz. (1 cup) every 15 minutes until ½ the container is finished
- Refrigerate the remaining ½.
- Bowel movements may be delayed. They may take time to start.
- Nausea is a common occurrence. Try to drink as much as possible. Vomiting is rare, but it does happen and is okay as long as you take as much as possible with lots of fluids.
- Mixing many times with Crystal Light flavor packs may help.



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Day of the Procedure

6 HOURS PRIOR to ARRIVAL

- Drink remaining NuLYTLELY mixture. ~ 8oz (1 cup) every 15 min
- May drink clear liquids only* (see list of clear liquids)
- May brush teeth

4 HOURS PRIOR to ARRIVAL

- **ABSOLUTELY NOTHING BY MOUTH - NO** gum; candy; mints; smoking, water.
May use Chap Stick for dry lips.
- **PLEASE BRING: Completed endoscopy health history form** (last page of the packet), inhalers, CPAP/BiPAP (if easily transportable), glasses (do not wear contacts), if menstruating can use a tampon, reading material or other items in case of unforeseen delays, a **copy of your medication list with dosing and the last time taken (including over the counter meds)**
- DO NOT BRING valuables, including jewelry.

The **ONLY MEDICATIONS** you may take this morning three (3) hours prior to your arrival are:

- Cardiac (heart)
- Seizure
- Blood Pressure
- Asthma medications and inhalers

IMPORTANT INSURANCE INFORMATION FOR PROCEDURES

Insurance Coverage

- **We strongly encourage you to check your coverage by calling your insurance company directly before any procedure is performed to find out what your benefits are.**
- Your insurance benefits may vary depending upon if you are having a screening colonoscopy or a diagnostic colonoscopy.
- If a biopsy is required or if a polyp is removed during your screening procedure, your insurance may need to process the claim differently.
- Your coverage might also vary based upon the location of your procedure – St. Joseph Hospital. If your insurance has trouble finding our facility in their directory, here is the Tax ID number: 02-0222215.
- If you are having another endoscopy procedure aside from a colonoscopy, please contact your insurance company for more information regarding coverage.

Out of Pocket Expense

- “Out of pocket expense” is defined as your share of the cost of your procedure and is determined by your insurance policy. For any endoscopic procedure, your insurance company determines the deductible and copayment amounts for which you are financially responsible.

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Communicating with Your Insurance Company

- What to ask:
 - “What is the coverage for my colonoscopy and/or upper endoscopy at St. Joseph Hospital Nashua, NH?”
 - “What are my ‘out of pocket’ fees for the procedure?” This will ensure you are fully informed of the possible costs you may incur prior to your procedure.
 - “Do I need a prior authorization for my procedure?” If yes, this will be obtained by our prior authorization team. For more information, contact their department at 866-620-4781.
- Anesthesia Fees
 - Anesthesia for SJH is provided by Narragansett Bay Anesthesiology.
 - Certain insurances may have restrictions on the coverage of anesthesia. We encourage you to review your individual benefits.
 - In general, if your major medical insurance covers your endoscopy procedure at St. Joseph Hospital, there should be no additional out of pocket fees for anesthesia.
 - For more questions regarding anesthesia and insurance coverage, please call Paula Jarrett for more information at 800-242-1131 extension 4108.
 - Your procedure will be submitted to your insurance company. All claims are billed out separately, by department (i.e. anesthesia, pathology, provider, and facility).
 - Facility, pathology, and provider fee is St. Joseph Hospital.

Financial Assistance

- **All non-covered services will be your responsibility to pay.**
- Financial assistance is available for patients who meet eligibility criteria. For more information, please contact the Customer Service department at 1-866-524-1189.
- Estimates for procedures can be provided by calling 603-578-5090.

What to Expect the Day of your Procedure

Arrival and Preparation

Your arrival time is noted in the packet. Please be sure to arrive on time. This allows you time to meet with the RN, an anesthesiologist and your gastroenterologist to complete the admitting process. We will review your medical history, have you meet with an anesthesiologist, and have you sign your consents for anesthesia and the procedure. An IV will be started and your vital signs recorded. We are expert at starting IVs; however, we welcome your feedback on placement. You will be lying on your left side, so we prefer to use the right arm/hand. We try to avoid the bend of the arm where blood is usually taken. Bruising is a normal occurrence after an IV and is to be expected.

Upon arrival you will complete a health history. This information may be in our computer system; however, this process is geared to gain as much updated knowledge as possible for the specific procedure. We thank you for your help.



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Although we do everything possible to avoid delays, the length of each procedure is variable. We assure you that we will take the time needed for your procedure when it is your turn. Please bring items to occupy your time and keep you relaxed. Headphones or ear buds for listening to music is one suggestion.

Sedation/Procedure

An anesthesiologist will administer anesthesia via IV. Patients receiving deep anesthesia fall asleep quickly and awaken once the procedure is completed. The medications used are determined by our anesthesiologist after careful consideration of your health status. Any medication given will require precautions for the remainder of the day. For those patients whose insurance does not cover anesthesia, nurses will administer sedating medication under the direction of the gastroenterologist. The goal of this type of sedation known as moderate sedation is comfort and reduced anxiety. The RN in your procedure room will aid in this process. The goal of the procedure is to examine your large intestine and remove polyps or tissue when needed for further evaluation in the lab. Generally, you will not feel when a polyp is removed or a biopsy is taken.

Recovery

You will be monitored for at least 30 min by an RN in the recovery area. Once awake we will offer refreshments and ensure you are ready to leave then remove your IV. Your ride should meet you in the recovery area or waiting room to escort you home. The gastroenterologist will briefly see you in recovery to ensure you are medically stable and give a brief preliminary finding. Any biopsy or polyp pathology results will be shared with you via correspondence from the physician's office. Your primary care physician or other referring physician will receive a copy of the results.

Most importantly, yes you can resume a normal diet after the procedure unless otherwise instructed. Feeling tired for the day is normal. Feeling slightly bloated, gassy or crampy is normal. A few drops of blood are normal. Any symptoms above and beyond should be reported to the gastroenterologist office right away. You will leave with discharge instructions and contact information.

Consent

You will have the opportunity to discuss the procedure with your gastroenterologist and the anesthesiologist regarding the sedation. They will each explain the nature of the procedure, its' risks, benefits and alternatives and have you sign a consent form that you understand and agree to the care.

The risks included as part of the consent discussion are but are not limited to; bleeding, infection, injury and/or perforation colon or small intestine, or adjacent organs such as the liver or spleen, the risk of missing lesions such as cancer, polyps or sources of bleeding, aspiration, medication side effects or allergic reactions, and other unforeseen complications. These risks may lead to the need for emergency room evaluation and care, the need for hospitalization, the need for additional procedures including but not limited to surgery and repeat endoscopic procedures (colonoscopy) and in very rare cases lead to cardiac arrest and death.



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ST. JOSEPH HOSPITAL ENDOSCOPY

YOUR NAME: _____

DRUG or FOOD ALLERGIES : No Yes please list _____

Personal Medical History: Please check all that apply and list any additional medical information below

- | | | | |
|----------------------------------------------|--------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Seizures | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> High Cholesterol | CPAP__ BIPAP__ | <input type="checkbox"/> Back Pain/injury | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Snores at night | <input type="checkbox"/> Cancer, | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> COPD | type_____ | <input type="checkbox"/> Falls in the past year |
| <input type="checkbox"/> Heart Problem* | <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dentures Upper / lower/
Partial (please circle) |
| If yes describe:
_____ | <input type="checkbox"/> GERD/Heartburn | <input type="checkbox"/> Low Thyroid | |
| | <input type="checkbox"/> Stroke <input type="checkbox"/> TIA | <input type="checkbox"/> High Thyroid | |

Surgery:

- | | | | | |
|--------------------------------------------------|-----------------------------------------------------------|--------------------------------------------|--------------------------------------|---------------------------------|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> C-Section | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Heart | <input type="checkbox"/> Abdominal Surgery | <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Joint Replacement, location_____ | | | <input type="checkbox"/> Other: |

When did you **DRINK FLUIDS** last including, your Prep: _____

Do you have any **metal in the body** (not teeth)? No Yes If yes where? _____

Females - Last **Menstrual Period:** _____ Any chance you could be pregnant? No Yes

Community Health Question- (unrelated to your procedure!) – Have you completed a living will or health care proxy? This is a formal document naming someone to make decisions for you if you are unable to do so.
 Yes No If no would you like **more information?** Yes No

If you have a list of your medications, please just GIVE it to the nurse - **DO NOT COMPLETE BELOW**
INCLUDE over the counter medications and herbals PLEASE.

Medication	Dose	How Often	Last Dose	Medication	Dose	How Often	Last Dose

Name of person taking you home today? _____ **Phone Number** _____

What Items do you have with you TODAY for the procedure? If you have any of these walking in we want to ensure you have them walking out! Keep valuables at home please. Circle all that apply

Dentures: full partial upper lower Glasses Hearing aids Cane Walker
Personal Wheelchair Other: _____

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