ST. JOSEPH HOSPITAL

Issued Date: _____

EGD/Upper Endoscopy Preparation Instructions

Thank you for choosing St. Joseph Hospital!

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 pre-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**.

Plan Ahead

- Call and check with your insurance company directly as soon as possible to determine if your procedure will be covered.
- If you develop a fever, cough, or any cold/flu like symptoms: or have any outstanding cardiac or respiratory testing, you MUST call us to reschedule.
- 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. We will unfortunately have to cancel your procedure if you fail to have a ride home available.
- If you need assistance with transportation: Gentle Care Ride offers medical transportation for a fee and services most of the Southern and Central New Hampshire Region. They can be reached by calling 603-341-1720 (they require at least two days' notice; however, please call early due to availability).

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Insurance Information

We strongly encourage you to check your benefit coverage by calling your insurance company directly before any procedure is performed to find out what your benefits are.

• Estimates for procedures can be provided by calling 866-620-4781.
• The standard CPT code for a colonoscopy is **45378** for both screening and diagnostic colonoscopies.
• If a biopsy is required or if a polyp is removed during your screening procedure, your insurance benefit may change.
• Your benefit coverage might also vary based upon the location of your procedure. If your insurance has trouble finding St. Joseph Hospital Nashua in their directory, our Tax ID number is: 02-0222215.
• If you are having an upper endoscopy (EGD) procedure in addition to your colonoscopy, please check with your insurance about coverage. The CPT code for an upper endoscopy (EGD) is **43235.**

Anesthesia Fees - Anesthesia for SJH is provided by Narragansett Bay Anesthesiology: 401-632-4464.
• Certain insurances may have restrictions on the coverage of anesthesia. We encourage you to review your individual benefits.

Medications

- If you take any oral iron supplements (not infusions), multivitamin w/iron, fish oil, or vitamin E, STOP these medications 7 days prior to your procedure.
- **If you take any of the medications listed below for diabetes and/ or weight loss on a DAILY basis, hold the medication for 24 hours prior to your procedure. If you take any of the medications listed below for diabetes and/ or weight loss on a WEEKLY basis, hold 1 week prior to your procedure. If taking any of the below medications for diabetes, please contact your prescribing doctor to find out if an alternative/ replacement is needed.**
  - Dulaglutide (Trulicity), Exenatide extended release (Bydureon bcise), Exenatide (Byetta), Semaglutide (Ozempic), Liraglutide (Victoza, Saxenda), Lixisenatide (Adlyxin), Semaglutide (Rybelsus), Phentermine (Adipex-P, Lomaira), Tirzepatide (Mounjaro)

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. ***Please do not stop taking your blood thinner without talking to your managing/prescribing physician.*** Aspirins are fine to continue.
- You are receiving Lovenox injections. These must be stopped 24 hours prior to your procedure.
- You are diabetic. Please check if medication adjustments are needed as you will be fasting.

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.

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Day Before Your EGD/Upper Endoscopy

You can eat normally throughout the day.

After MIDNIGHT (leading into the morning of your procedure) – NO SOLID FOODS, NO FULL LIQUIDS, NO DAIRY PRODUCTS, OR ALCOHOL. **Remain on a clear liquid diet only.**

ALLOWED	AVOID
Water	No milk, dairy, or dairy substitutes
Black coffee/ tea (no milk, creamer)	No RED, ORANGE, or PURPLE liquids
Clear juices that are not red, orange, or purple	No grape, fruit punch, or cranberry juice
Clear broths	No juice with pulp (ex. Orange Juice)
Popsicles	No smoothies
Jell-O	No nut milks
Coconut water	

Morning of Your EGD/Upper Endoscopy

Please continue to remain on a clear liquid diet only. No solid food/full liquids are allowed.

4 HOURS PRIOR TO ARRIVAL: ABSOLUTELY NOTHING BY MOUTH - NO gum; candy; mints; smoking, water. May use Chap Stick for dry lips.

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

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

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EGD/Upper Endoscopy Day Expectations

We ask that you please bring these items with you: **Completed endoscopy health history form** (last page of the packet), the name and phone number of your ride, 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).**

Please DO NOT BRING: Any valuables, including jewelry.
Please remove all body and facial piercings prior to coming in for your procedure.
If you wear dentures, please do not use denture adhesive on the day of your procedure, as they may need to be removed.

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

Please expect to be at the hospital for about 2 ½ to 3 hours. We make every effort to remain on time, but delays may occur.

You will need to rest for the remainder of the day. Do not operate any machines or motor vehicles.

You will receive a letter explaining your results approximately 2 to 3 weeks after your procedure.

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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

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

Surgery:

☐ Appendectomy	☐ Gallbladder	☐ Hysterectomy	☐ C-Section	☐ Hernia
☐ Tonsillectomy	☐ Heart	☐ Abdominal Surgery	☐ Eye Surgery	☐ Other:
☐ Pacemaker/Defibrillator	☐ Joint Replacement, location_____			☐ 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:_____