Digestive Health Care

TARIQ HASSAN MD

Gastroenterology

Getting ready for your colonoscopy

TWO DAYS before your test stop eating raw fruit and vegetables, corn , nuts seeds and pop corn. No apples, salad, lettuce, broccoli, carrots. These will be difficult to cleanse from colon.

On the morning, ONE DAY BEFORE you test, start a clear liquid diet. For example WATER, Flavored Water, Apple Juice, White grape juice, lemonade. Ginger ale, soda like mountain dew, sprite coke or pepsi. Black coffee or tea with NO milk or creamer is OK. Gatorade, chicken or beef broth or bullion, jello and popsicles can be eaten.

These products are the only food to be taken for breakfast , lunch and dinner. If you test if on Monday you will start the prep Sunday morning. Don't eat anything red or purple. Do not eat any solid food.

You can have the clear liquid diet up to 3 hours before the time of your test.

The bowel preparation solution will come in a bottle or jug labeled PEG 3350 or Golytely). Use the enclosed prescription to get this from your pharmacy.

Mix this prep on the morning before your test and put in the fridge. Flavor packets usually come with the jug.

Drink half the prep solution at 4 pm the day before your test and the remaining half at midnight. Buy Dulcolax laxative tablets over the counter and take two tablets at 8 pm.

If you throw up the solution take 4 Dulcolax tablets instead of the dose you threw up. With this prep your stool should become clear by the morning of your test.

MedicinesDo not take Aspirin , Aleeve , Motrin , Advil , Ibuprofen or iron pills 5 days before your procedure. Stop Plavix , Pradaxa , Effiant or Xeralto 5 days prior to your procedure. Do not take Coumadin, warfarin, or Elaquis 3 days before your test.

Take your medicines for blood pressure, heart, anxiety , seizure and asthma the morning of your procedure with sips of water. Bring any inhalers you use with you. If you are diabetic do not take your pills on the morning of your procedure. For insulin take HALF your usual dose the day before but NONE on the morning of your procedure. Check your blood sugar one morning of your procedure if you have a machine and if over 300 call 314 373 8931 ask for anesthesia provider.

Any questions call the office 314 529 0661 and speak to Samantha or Ashley. Visit our web site www.colonage50.com to down load lost forms, watch video for colon prep

Digestive Health Care

TARIQ HASSAN MD

Gastroenterology

(Please print)

Demographics:

Patient Name (Last, First, Middle Initial):____

Address:________________________City:______________State:________Zip:__________

Home Phone: (_____)______________Cell: (_____)______________Work: (_____)______________

Patient SSN:________-_______-________ Date Of Birth _____/_____/________ Sex: M________F________

Marital Status: S M W D Ethnic Background (Please circle one) Hispanic or Latino / Neither Hispanic or Latino

Race: (Please circle) 1) White 2) Black or African American 3) American Indian or Alaska Native 4) Asian

5) Native Hawaiian/Pacific Islander 6) Other not listed 7) Multi-Racial (two or more races) 8) Choose not to answer

Referring Physician Name:________________________ Office Number:________________

Medical Insurance Information:

Primary Insurance Company:________________________ Phone Number:________________

Policy/Member ID Number: ________________________ Group Number: ________________

Relationship to Policy Holder:________________________ Policy Holders Date of Birth: ____________

Secondary Insurance Company:________________________ Phone Number:________________

Policy/Member ID Number: ________________________ Group Number: ________________

Relationship to Policy Holder:________________________ Policy Holders Date of Birth: ____________

Responsible Party Signature: ____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS:

I hereby authorize the release of any medical information necessary to process my health claims and request payment of benefits to the provider of service(s). I permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible to the providers(s) for charges not covered or denied by my insurance company. I further agree in the event of my non-payment, to pay the cost of collection and/or court costs and reasonable fees should this be required. I have been informed prior to the date of my scheduled procedure that the physician who is rendering services may have an ownership interest in the above referenced facility. I have also been given the choice to schedule my procedure at another facility. I wish to be treated at Digestive Health Care physicians.

Signature:____ **Date:**________________

THE ENDOSCOPY AND COLONOSCOPY CENTER

100 Village Square, Hazelwood MO, 63042. Ph: 314-373-8931

Digestive Health Care

TARIQ HASSAN MD

Gastroenterology

Date ________________ Allergies ____

Patient: ____ D.O.B. ____________________

Pharmacy Phone#: ________________________________

Medication	Dosage	Frequency	Prescribed By
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Dear Patient:

The procedure that you are scheduled for will **Prohibit** you from operating a motor vehicle. To ensure the highest quality of safety for everyone, please be sure to arrive with an acceptable form of transportation. EMT (314-781-6400) is accepted at this facility. Cabs are not acceptable.

If you are being dropped off, your responsible party(transportation) is required to be available at the time of check in. During the time of check in, you will receive information regarding "Check Out" and "Transportation". Your procedure can take up to 3 hours.

If you are unable to obtain proper transportation, you will need to call the office 314-355-4010 to reschedule. All appointments are required to be cancelled/rescheduled within 24 hours. Patients failing to cancel/reschedule as required will receive a $150.00 non-cancellation fee.

Any questions regarding transportation, please call our office.

ACKNOWLEDGEMENT

I ______________________________ have read the above instructions, and I acknowledge that I am REQUIRED to have the appropriate **RESPONSIBLE PARTY/TRANSORTATION** in attendance at the time of check in for my appointment.

Patient Signature: ____ Date: ______________

THE ENDOSCOPY AND COLONOSCOPY CENTER

100 Village Square, Hazelwood MO, 63042. Ph: 314-373-8931

Digestive Health Care

TARIQ HASSAN MD

Gastroenterology

Name: ______________________

Age: ______________________

Referring Physician: ______________________

Date of Birth: ______________________

A) REASON FOR VISIT

____

____

How does this affect your lifestyle? __________

Increased Appetite? Yes______ No ______

Decreased Appetite? Yes ______ No ______

Recent Weight Change? Yes ______ No ______

If "yes" how much over what length of time?

____

Prior problems with anesthesia? Yes _____ No ______

If "yes" please describe______________________

____

B) PATIENT PROFILE (CIRCLE ONE)

Married Divorced Single Separated Widowed

Last medical examination______________________

Occupation: ______________________

Years retired: ______________________

Smoking: Pipe ________Cigarettes ____________

Chewing Tobacco ______________________

Coffee: more than two cups per day ____________

Alcohol: ____________ ______glasses per day

____

Beer / Wine: ____________ ______glasses per day

____

C) HOSPITALIZAION AND/OR SURGERIES

____

____

____

D) Do you have pain now or have you had pain in the last several weeks? Yes ___ No___ If yes, how would you rate the level of pain on a scale of 1 – 10 with 10 being the worst? _____ Describe the pain. Where is it located? What aggravates it? What alleviates it? How long does it last? ______________________

____

____

____

E) MEDICATION ALLERGIES:

____

____

____

____

____

F) MEDICAL HISTORY (Please Circle)

High Blood Pressure, Heart Disease, Diabetes,

Kidney Problems, Liver Disease, Arthritis, Breathing Difficulty

Vision Problems, Stroke, Seizures, Hearing Difficulty

Other: ______________________

____

______________________ ______________________

Patient Signature Date

______________________ ______________________

Nurse Signature Indicating Review Date

______________________ ______________________

Physician Signature Indicating Review Date

THE ENDOSCOPY AND COLONOSCOPY CENTER

100 Village Square, Hazelwood MO, 63042. Ph: 314-373-8931