MITCHELL ENDOSCOPY CENTER

UPPER ENDOSCOPY INSTRUCTIONS

YOU MUST STOP TAKING OZEMPIC, TRULICITY, WEGOVY, MOUNJARO, SEMAGLUTIDE, SAXENDA OR ANY OTHER GLP-1 AGONIST AT LEAST **7 DAYS** BEFORE YOUR PROCEDURE – YOUR PROCEDURE WILL BE CANCELED IF THIS IS NOT FOLLOWED AS THIS IS A SAFETY ISSUE AND COULD RESULT IN SERIOUS MEDICAL COMPLICATIONS. PLEASE CALL OUR OFFICE WITH QUESTIONS OR CONCERNS AT 804-282-3114.

- YOU WILL BE SEDATED. YOU WILL NEED TO HAVE SOMEONE YOU KNOW DRIVE YOU HOME. YOU CANNOT DRIVE YOURSELF HOME. YOU CANNOT TAKE A CAB. **YOUR DRIVER WILL NEED TO STAY THE ENTIRE TIME DURING YOUR PROCEDURE.**

- **DO NOT EAT ANYTHING** AFTER MIDNIGHT BEFORE YOUR EXAM.

- **YOU MAY HAVE CLEAR LIQUIDS ONLY BEFORE YOUR TEST BUT YOU MUST STOP DRINKING ALL LIQUIDS (INCLUDING WATER) 3 HOURS PRIOR TO YOUR TEST OR IT WILL BE CANCELED.**

- YOU WILL WANT TO RELAX THE REST OF THE DAY FOLLOWING YOUR PROCEDURE.

- STOP ALL ASPIRIN AND BLOOD THINNERS 3 DAYS PRIOR TO THE TEST.

FOR OFFICE USE ONLY
ARRIVAL TIME: _____

DATE OF PROCEDURE:_____

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PRE-PROCEDURE ASSESSMENT
(Please complete all questions and sign)

Name: _____ DOB:_____ Family Doctor: _____

Why are you having this procedure?_____

Who is driving you home?_____ Is he/she here now? YES NO

Past Medical & Surgical History:	**YES**	**NO**	**If yes, please explain:**
Do you have an Advanced Directive?			
Heart Murmur/Valvular Heart Problem?			
Heart Disease (Coronary Artery Disease, Arrhythmias, A-Fib)?			
Pacemaker or Defibrillator?			
Stroke or TIA (mini stroke)?			
Seizure?			
Liver Diseases?			
Kidney Problems?			
Respiratory Lung Problems?			
Sleep Apnea? Do you use a CPAP or BIPAP?			
Bowel Disease or Surgery?			
Cancer?			
Glaucoma?			
Diabetes?			
High Blood Pressure?			
Blood Disorder (HIV, Anemia, Hepatitis)?			
Previous Problems with Sedation/ Anesthesia?			
Are you wearing dentures?			
Are you wearing a hearing aid?			
Do you have artificial joints/implants?			
Are you pregnant? N/A			Date of last menstrual period:
Are you on blood thinners? **Circle:** Coumadin, Aspirin, Plavix, Eliquis, Xarelto, Brilinta, Aggrenox			Other: _____ Date stopped: _____

Other medical issues not listed above? _____

Please list any previous surgeries: _____

Drug Allergies: YES NO If yes, list:_____

Latex Allergy/Sensitivity: YES NO What bowel prep did you use: _____

Tobacco Use: Y N # Packs:_____ Last time you ate solid food: _____@_____

Alcohol Use: Y N Amount:_____ Last time you had liquids:_____@_____

Recreational Drug Use: _____ Height: _____Weight_____

Medication	**Dosage/Frequency**	**Reason for taking**	**Last Taken on**

Completed by (Patient's Signature) _____ Date: _____

Reviewed by (Nurse's Signature) _____ Date: _____