

DIGESTIVE DISEASE SPECIALISTS, INC.

Southwest Office
Barry G. Perkins, MD
Southwest Medical Center Campus
4201 S. Western
Oklahoma City OK 73109
(405) 632-4000

NAME: _____

DATE OF PROCEDURE: _____

ARRIVAL TIME: _____

PROCEDURE TIME: _____

Procedure Location:

1 Ambulatory Endoscopy Center / South
4201 South Western
Oklahoma City, OK
Check in at ADMISSIONS

2 Southwest Integris Medical Center
4401 South Western
Oklahoma City, OK
Check in at the Outpatient Entrance front desk

Thank you for choosing Digestive Disease Specialists, Inc. for your medical care. If you have been scheduled for an appointment, please read the following guidelines and print the appropriate forms to bring with you to your appointment. We hope the following information will answer any questions you may have.

VISICOL COLONOSCOPY PREP – AFTERNOON PROCEDURES

You have been scheduled for an out patient Colonoscopy at the above noted date and time. Please read the following information to help you understand your procedure.

You will be on a liquid diet the entire day prior to your procedure. Please see attached Liquid Diet Sheet. You may continue the liquid diet until _____ AM the morning of the procedure.

After you have checked into the facility, you will be taken to a room to have your blood pressure, pulse, and temperature taken. You will be asked to remove your comfortable clothing and put on a gown. A nurse will start your IV to administer medication that will relax you and make you sleepy for the procedure.

The colonoscopy is performed with the help of video equipment. The doctor will guide the scope (A small tube with a lens and a light source that allows him to view the colon.) into your colon. If necessary, biopsies may be taken through this instrument. You will feel no discomfort when the biopsy is taken. This exam will take approximately 15-20 minutes.

After the test is completed, you will remain at the facility for about one hour. This is to make sure you have no complications, and have recovered sufficiently from the medications.

Please make arrangements to have a responsible adult to drive you home after the procedure. You may not drive a vehicle or operate heavy machinery the rest of the day. **The procedure will not be performed if there is not responsible adult to escort you home.**

When you return home, you may experience some rectal bleeding. This should not last more than a day nor be accompanied by pain. Any unusual symptoms such as: fever, excessive rectal bleeding or severe abdominal pain may indicate a complication and should be reported to this office **immediately**.

If you have any questions prior to your procedure, please call our office at **632-4000**.

DIABETES

If you are an insulin dependent diabetic or using an insulin pump, please contact the doctor that treats your Diabetes to get instructions on how to adjust your insulin for the day before your procedure when you are on a liquid diet. On the day of the procedure, you should not take your insulin before your procedure. You may want to bring your insulin and syringes with you if you need to take your insulin before you arrive home. The facility does not keep diabetic medications or supplies and can nor administer the insulin.

If you are on oral medication, please take the medication as usual the day before the procedure and do not take the morning of the procedure. You may want to bring your medications with you to take after the procedure.

BLOOD THINNERS

If you take any type of blood thinners including aspirin, please inform the nurse for further instructions.

PACEMAKERS – DEFIBRILLATORS – ARTIFICIAL HEART VALVES

It is very important that both the doctor and nurse scheduling the procedure are aware that you have pacemaker, defibrillator, or have any artificial heart valves. Please make sure you give them all information.

PROCEDURE RESULTS

You have given the office a contact phone number for your results. You will be called at this number within 2-4 days after your procedure.

SPECIAL INSTRUCTIONS FOR PATIENT:

PLEASE SEE ATTACHED SHEET THAT OUTLINES YOUR PREP INSTRUCTIONS.

******IF YOU ARE A NEW PATIENT OR IF YOU HAVEN'T BEEN SEEN BY YOUR PHYSICIAN WITHIN ONE (1) YEAR, PLEASE PRINT THE FORMS AT THE FOLLOWING LINK: [Pre-Registration Forms](#). PLEASE FILL OUT ALL FORMS AND BRING THEM WITH YOU TO YOUR PROCEDURE. THANK YOU.******

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VISICOL PREP SHEET **AFTERNOON PROCEDURE**

FIRST DOSING REGIMEN

BEGIN YOUR **FIRST DOSING REGIMEN** AT 5:00 PM THE EVENING PRIOR TO YOUR PROCEDURE.

FIRST DOSE: START DATE _____ @ 5:00 PM

_____ DOSE 1 @ 5:00 PM 4 TABLETS W/ 8OZ LIQUID

_____ DOSE 2 @ 5:15 PM 4 TABLETS W/ 8OZ LIQUID

_____ DOSE 3 @ 5:30 PM 4 TABLETS W/ 8OZ LIQUID

_____ DOSE 4 @ 5:45 PM 4 TABLETS W /8OZ LIQUID

_____ DOSE 5 @ 6:00 PM 4 TABLETS W/ 8OZ LIQUID

DO NOT EXCEED 20 TABLETS FOR THE FIRST DOSING.

SECOND DOSING REGIMEN

BEGIN YOUR **SECOND DOSING REGIMEN** AT THE TIMES AND DATE LISTED BELOW.

SECOND DOSE: START DATE _____ @ _____ AM

_____ DOSE 1 @ _____ AM 4 TABLETS W/ 8OZ OF LIQUID

_____ DOSE 2 @ _____ AM 4 TABLETS W/ 8OZ OF LIQUID

DO NOT EXCEED 8 TABLETS FOR THE SECOND DOSING.

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Start morning of: _____

Day of Procedure: NOTHING AFTER _____

FULL LIQUID DIET

<u>Food Groups</u>	<u>Food Allowed</u>	<u>Food to Avoid</u>
Fruit	Apple Juice Grape Juice Cranberry Juice	Any Juice with Pulp (no orange juice)
Soup	Fat-Free or Low Fat: Chicken Broth Beef Broth Chicken Bouillon Beef Bouillon	All Others
Dessert	Jell-O, any flavor plain <u>(No red or purple dyes)</u> Ice Popsicles <u>(No red or purple dyes)</u>	All Others
Beverages	Water, Ice Coffee, <u>no milk or cream</u> Tea Any Carbonated Drinks <u>Ensure (1-2 drinks maximum)</u>	All Others
Miscellaneous	Salt Sugar Hard Candy	All Others