Gastro Health

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**Reston**
1939 Roland Clarke Place
Suite 200
Reston, VA 20191
703-435-3366

Procedure Scheduling for
Reston Hospital Center, Reston
Surgery Center and
Reston Endoscopy Center
703-435-3366

**Reston Hospital Center**
1850 Town Center Parkway
Reston, VA 20190
703-689-9000

**Reston Endoscopy Center**
1939 Roland Clarke Pl
Suite 200
Reston, VA 20191
703-435-3366

**Reston Surgery Center**
1860 Town Center Drive
St. G100
Reston, VA 20190
703-639-3100

***PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY AT LEAST TWO WEEKS BEFORE YOUR PROCEDURE:***

If you have any questions, please do not hesitate to call our office.

# COLONOSCOPY INSTRUCTIONS

- Prescribed medications for heart disease, high blood pressure and asthma may be taken prior to your procedure. All other medications, including diabetic medications, should be brought along with you to be taken after your procedure.
- Please stop Plavix 5 days prior to your procedure, or Coumadin 4 days prior. Please do not stop either of medication without consulting your prescribing physician.
- If you are taking iron, this **<u>MUST</u>** be stopped 7 days prior to your procedure.
- **<u>DO NOT</u>** eat foods containing seeds for five days prior to your procedure, i.e. sesame or poppy seeds, strawberries, black pepper, corn or tomato skins. Do not eat olestra potato chips. If by chance you have eaten these products, still proceed with your preparation.
- Please advise the physician if you have a <u>prosthetic heart valve</u> or if you have a <u>serious heart murmur</u>. Also advise physician if you have had any cardiac procedures in the last year.
- On the day of your colonoscopy you will receive intravenous sedation. **These medications will impair your driving ability.** You must arrange for someone to take you home after your procedure. You may not drive until the next day.
- **<u>Your procedure will take place at one of the following sites:</u>**

1. **Reston Hospital Center (703) 689-9000** – report to the Same Day Surgery department at least 2 hours prior to your scheduled procedure.
2. **Reston Endoscopy Center (703)435-3366 –** report to the center at least 30 minutes prior to your scheduled procedure.
3. **Reston Surgery Center (703) 639-3100** – report to the center at least 1 hour prior to your scheduled procedure.

The physician will give you written instructions with regards to eating after your colonoscopy.

This packet contains the **Golytley Prep**. If you are unable to complete the prep, please call the Doctor's office line and the Physician on call will contact you.

# Golytley Prep for Colonoscopy:

## At Least One Week before the Procedure:

1. Fill the prescription for Golytely.

## One Day before the Procedure:

1. Begin a clear liquids diet starting at breakfast and continue for the entire day. See attached list for "Clear Liquid Diet". Drink at least eight to ten 8 fluid ounce glasses of liquid throughout the day.

2. In the morning (the day before the procedure), fill your Golytely bottle with water. Refrigerate mixture.

3. At 6:00 p.m. add the flavor packet to the mixture, and drink one 8 ounce glass of the solution every 10-15 minutes until half of the solution has been consumed.

4. **Continue to drink as much clear liquids as possible until bedtime**.

## The Morning of the Procedure:

1. **Wake 5 hours before your procedure time** and complete the Golytely solution over 1 hour. If you feel you will need more than 1 hour to complete the remaining solution, please adjust the time you are waking up.

2. Upon finishing the solution, **NOTHING** by mouth is permitted. This includes mints, gum, ice cubes, etc.

3. It is OK to take your blood pressure or heart medication with enough water to swallow the medications. DO NOT take diabetes medication WITHOUT PRIOR INSTRUCTION from your Primary Care Physician (your dosage may have to be adjusted). Clear liquids are allowed up to 6 hours before procedures.

If you have any questions or concerns, please call our office, 703-435-3366.

# CLEAR LIQUID DIET

This diet provides fluids that leave little residue and are easily absorbed with minimal digestive activity. This diet is inadequate in all essential nutrients and is recommended only if clear liquids are temporarily needed. **No red or purple** liquids should be consumed!

| Food Group | Foods Allowed | Foods to Avoid |
|---|---|---|
| Milk & Beverages<br>*No red or purple liquids!* | Tea and coffee (no creamer), carbonated beverages, fruit flavored drinks | Milk, creamer, milk drinks |
| Meats & Meat Substitutes | None | Fruit juices with unstrained fruit |
| Vegetables | None | |
| Fruits & Fruit Juices | Strained fruit juices: apple, white grape, lemonade | |
| Grains & Starches | None | |
| Soups | Clear broth, consommé | |
| Desserts | Clear flavored gelatin, popsicles<br>*No red or purple flavors* | |
| Fats | None | |
| Miscellaneous | Sugar, honey, syrup, clear hard candy, salt | |

**The following menu is only a suggestion**

**Breakfast**
4 oz. White grape juice
6 oz. Clear broth
JELL-O®*
Tea

* Plain only, no fruit or toppings

**Lunch**

4 oz. Apple juice 6
oz. Clear broth
JELL-O®*
Tea

**Dinner**
4 oz. Lemonade
6 oz. Clear broth
JELL-O®*
Tea

Jell-O is a registered trademark of Kraft General Foods, Inc.

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1. I, _____________________________ hereby request, consent to, and authorize Dr. Wolke, Dr. Plotner, Dr. Axelrad, Dr. Noguera, Dr. Valle, and Dr. Lakhani (the "Practitioner") and such surgical assistants as may be selected by him/her to perform the following procedure(s): **colonoscopy with possible biopsy**. Risk of drug allergy, over sedation, aspiration, bleeding, perforation and need for surgery have been explained to me. The Practitioner has advised me there is a small possibility of missing lesions.

2. It has been clearly explained to me that during the course of this operation, some other conditions which had not been expected may present themselves. I recognize that if such conditions are discovered it will be necessary to do more than that which is specified in paragraph #1 above. I, therefore, authorize and request that the above named Practitioner and his/her surgical assistants perform such surgical procedures which, in their best professional judgment, will be effective in their attempt to heal and/or diagnose. This includes, but is not limited to, pathology and radiology. I further authorize the Anesthesiologist or nurse anesthetist selected by the Anesthesiologist to administer whatever anesthesia they feel is indicated; and authorize the use of blood transfusions when attending personnel feel such is required.

3. I fully understand that this operation, like any operation, is accompanied by some degree of risk and that no cure is guaranteed.

4. The nature of my (or the patient's) condition, the nature of the procedure(s) listed under paragraph #1 above, the risks involved and whatever other choices are available to me (or the patient), if any, have been explained by a representative of The Gastroenterology Group, P.C. and I have been given the opportunity to ask any questions that I may have regarding that explanation and my questions have been answered satisfactorily.

______________________________ ____________ ______________________________ ____________
Signature of Patient Date Signature of Witness Date

______________________________ ____________
Signature of Next of Kin or Guardian Date

PHYSICIAN'S STATEMENT:

*I have personally explained, in non-technical terms, the proposed procedure to the patient, and/or relative/guardian, the major risks or consequences of this procedure, and any alternatives.*

______________________________ ____________
Signature of Physician Date

**OPERATIVE REQUEST/CONSENT**

(Colonoscopy)