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PATIENT INSTRUCTIONS FOR UPPER ENDOSCOPY
EGD*
*ESOPHAGOGASTRODUODENOSCOPY

1. NOTHING TO EAT OR DRINK after midnight. **May have clear liquid 4 HOURS BEFORE PROCEDURE.** ***You should be accompanied by a driver.***

2. CONTINUE ALL **BLOOD PRESSURE MEDICINES** ON DAY OF PROCEDURE (Unless instructed of change)

3. DAY OF PROCEDURE, **HOLD DIABETES MEDICINES TAKEN BY MOUTH** (such as metformin, glimepiride, glipizide, glyburide, pioglitazone, rosiglitazone, nateglinide, repaglinide, alogliptin, linagliptin, saxagliptin, sitagliptin, and combination medications, canagliflozin (Invokana), dapagliflozin (Farxiga), etc. **Long- Acting Insulin Analogs** such as Toujeo, Lantus, Tresiba and Levemir should be ***continued without change***. For other insulin products, such as ***Regular*** **insulin** and ***intermediate- Acting NPH***, ***take ½ dose on day of procedure.***

4. **No need to stop** *Aspirin or other NSAIDs (ibuprofen, Celebrex, naproxen, etc* **– NEW RECOMMENDATION) - UNLESS INSTRUCTED**

5. **Get (or we will) get recommendations from your prescriber at the time of your office visit if you are on the following medications prior to scheduling your procedures. {*Anticoagulants* – Savaysa (**edoxaban**), Eliquis (**apixaban**), Xarelto** (rivaroxaban)**, Pradaxa (**dabigatran**)} or [*Antiplatelet* – Zontivity (**vorapaxar**), Plavix** (clopidogrel)**, Brilinta (**ticagrelor**), Effient (**prasugrel)**]**

6. You will be required to sign a CONSENT FORM prior to your EGD. Your signature on this form indicates that the EGD procedure and possible biopsy and/or tissue removal have been explained to you in detail and to your satisfaction by your provider, including the more common **risks, benefits, and alternatives** of the procedure, and your full understanding of these. **The risks,** which may be life-threatening and can result in death include, but are not limited to, **the risks of the sedation affecting your breathing and/or heart; the risks of bleeding and/or infection; aspiration; the risk of perforation** (a hole or tear in a structure) which may require surgery(s) for repair; lack of 100% accuracy; damage to natural or artificial teeth or oral structures. You further acknowledge that every conceivable risk, complication, and consequence, alternative, and benefit has not and cannot be explained, and that complications can occur even if all is performed correctly and appropriately by those involved in your care. No guarantees regarding the procedure or its outcome have been made. If you should have any questions or concerns regarding your EGD, or have had an adverse reaction to sedation, endoscopic procedures, or surgery in the past, please inform your provider.

OVER

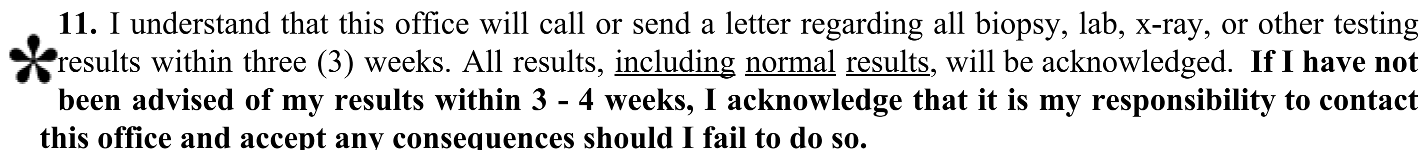
7. At the time of the procedure, you should not be pregnant. Inform your provider if you could be pregnant, preferably at least one (1) day before the procedure. A pregnancy test may be ordered; note that a NEGATIVE pregnancy test does NOT guarantee with 100% certainty that you are not pregnant.

8. Because you will receive sedation, a responsible adult (friend or relative) MUST accompany you AND STAY at the endoscopy center during your procedure. If this is an issue for you, please discuss your situation with the manager at the endoscopy center at 301.668.1600. The adult MUST also accompany you home from the endoscopy center, or the hospital. Furthermore, for the remainder of the day you should not:

(1) drive
(2) operate hazardous equipment
(3) go to work
(4) sign legal documents, etc.

9. If you should experience any fever, chills, chest, back, shoulder, or abdominal pain, bleeding, nausea, or vomiting, or any other problem, please do not delay in calling the doctor.

10. If you have not been informed within 2 weeks regarding the results of biopsies, polyps, etc., please call.



* **11.** I understand that this office will call or send a letter regarding all biopsy, lab, x-ray, or other testing results within three (3) weeks. All results, including normal results, will be acknowledged. **If I have not been advised of my results within 3 - 4 weeks, I acknowledge that it is my responsibility to contact this office and accept any consequences should I fail to do so.**

12. Please note that, once your insurance has determined your benefit based on your policy, you MAY receive SEPARATE billing statements from your gastroenterologist, the facility, anesthesiologist, and pathologist. Please note the heading on the billing statement and contact that office should you have questions.

I ACKNOWLEDGE RECEIPT AND UNDERSTANDING OF THE PATIENT INSTRUCTIONS FOR UPPER ENDOSCOPY-EGD INFORMATION SHEET (2 SIDES), WHICH I HAVE REVIEWED WITH PROVIDERS AND STAFF.. BY SIGNING THIS INFORMATION SHEET AND THE CONSENT FORM, I AM INDICATING THAT WHAT THESE DOCUMENTS SAY IS TRUE. I HAVE SPECIFICALLY READ, UNDERSTAND, AND AGREE WITH ABOVE. MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I AGREE TO PROCEED.

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Signature of Patient (and PRINT) Date