NORTHERN COLORADO
ENDOSCOPY
CENTER

8227 W 20th Street
Greeley, CO 80634
Ph: (970) 573-7555
F: (970) 744-5309

Personal History Packet

Please read this entire packet
Fill out **all** paperwork in its entirety:

- Tell us about yourself
- Medication – if you have a list already made, please attach a copy to this form
- Consent form

Please bring the above forms with you to the appointment.

*We are not part of UCHealth or Banner

*We do not have access to outside medical records

SIGMOIDOSCOPY PREP

Your physician has scheduled you for a Sigmoidoscopy. Please follow the instructions below.

- ❑ If you need to cancel or reschedule your procedure for any reason, please call the Endoscopy Scheduler at 970-573-7555 at least 48 hours prior to your exam.
- ❑ If you are unable to complete your prep, notify the Northern Colorado Endoscopy Center at 970-573-7555. For questions after hours call 970-378-1414 and ask for the gastroenterologist on-call.
- ❑ **Completely fill out the "TELL US ABOUT YOURSELF" and "MEDICATION" forms in your packet. Bring the completed forms and your packet with you the day of your procedure.**

General Information:

- ✓ For 5 days prior to your procedure, try to avoid nuts, seeds and corn.
- ✓ Take your prescribed medications as you normally would up until 3 hours before your procedure.
- ✓ If you do not receive sedation, you will be able to drive yourself home.

If you receive sedation:

- ✓ Make arrangements to have a responsible adult drive you home. Your driver should plan to stay at the facility during your procedure. Public transportation (bus, taxi, shuttle) is NOT allowed unless you have a responsible adult with you.
- ✓ After the procedure, you should have an adult with you for 4 to 6 hours.

In advance, you will need to purchase 2 fleets enemas from your pharmacy.

- ❑ Consume only clear liquids after midnight the evening prior to and the day of your test. If you are receiving sedation, do not drink anything for 3 hours before your exam.
- ❑ Use both Fleets Enemas 1 1/2 hours prior to the exam, 10-15 minutes apart.
- ❑ Take your prescribed medications as you normally would up to 3 hours before your procedure, except for diabetic and blood thinning medications (see instructions for diabetic medications below, call 970-378-1414 for directions regarding blood thinner).

DIABETIC INSTRUCTIONS:

- ✓ If you are a diabetic and your procedure is scheduled to be done in the morning, hold your medications or insulin the morning of the procedure. We suggest you check your blood sugar at least 4 times a day at mealtime and bedtime.
- ✓ If you are diabetic and your procedure is scheduled to be done in the afternoon, contact your primary care physician to confirm how to take your diabetic medication. We suggest you check your blood sugar at least 4 times a day at mealtimes and bedtime.

ABOUT YOUR SIGMOIDOSCOPY

Dear Patient:

Your physician has referred you for a sigmoidoscopy. The purpose of this letter is to familiarize you with the nature of the exam, its benefits and its risks. What follows is absolutely essential for you to know, so please read this carefully. We consider your understanding of this material to be so important that we will ask you to sign this letter acknowledging you have read and understood this information. If you have any questions, please contact us by phone (970-573-7555) before the procedure so we can discuss your concerns with you.

Why you should have a sigmoidoscopy:

A sigmoidoscopy is an examination of the lower portion of the colon (large intestine) using a long, thin, flexible tube with a camera on the tip called a colonoscopy. The procedure is done for a number of different purposes, such as evaluation of colitis, diarrhea, rectal bleeding, or for follow-up of a polyp.

The procedure:

The actual examination usually takes between 10 and 15 minutes. You will be positioned comfortably on your left side in a bed. The setting is calm and private.

If you do not receive sedation, you may experience some mild lower abdominal cramping. You can be discharged immediately after your procedure and can drive yourself home.

If your doctor has recommended sedation, an IV will be started prior to your procedure in order to give the necessary medications. Heart and lung function monitors are used to enhance safety. Because of the medications, you will probably remember little or none of the procedure. It is unlikely that you will find the examination to be unpleasant. After the procedure, it will take you about half an hour to wake up enough to leave the endoscopy center. Most people are in and out of the endoscopy center in about two hours. Because of the sedation, you will need a ride home. You will not be able to drive for at least 12 hours. You will probably be able to resume most of your normal activities about six hours after the procedure.

If polyps are removed, there is a small risk of bleeding for up to two weeks afterwards. For this reason, you should only have the procedure done if you will be within easy reach of an emergency room for the next 14 days.

Examples of activities you need to avoid for two weeks after polyps are removed include travel in airplanes and backcountry recreation. It is fine to drive to areas with reasonable levels of emergency medical care.

Please contact us at 970-573-7555, if you would like to discuss any of this further. You will, of course, have an opportunity to speak to us immediately before the procedure.

Drs. Strong, North, Sears, Langer, Caufield, Dunphy, Durkan, Jenkins, Kershner, Hampton, Huerta, Webb and Settergren have a financial ownership in Northern Colorado Endoscopy Center.

Sincerely Yours,

Centers for Gastroenterology Physicians

By signing here, you certify that you have read and understood the information pertaining to the Sigmoidoscopy. If you have questions, please do not sign this until we have answered them for you.

Signature _____ Date_____

Name _____ Date of Birth _____

TELL US ABOUT YOURSELF

Please complete this form and bring it and this packet to your procedure.

Why are you having this procedure? _____

Do you take blood thinning medication? ❑ Yes ❑ No ***Are you, or could you be, pregnant?*** ❑ Yes ❑ No

Do you use oxygen at home? ❑ Yes ❑ No ***Amount of oxygen used*** _____

Do you smoke or use tobacco products? ❑ Yes ❑ No ***Amount/Frequency*** _____

Do you drink alcohol? ❑ Yes ❑ No ***Amount/Frequency*** _____

Do you use marijuana products? ❑ Yes ❑ No ***Amount/Frequency*** _____

Do you currently have any of the following medical conditions or history of? If yes, please briefly explain.

❑ Yes ❑ No Diabetes _____
❑ Yes ❑ No High Blood Pressure _____
❑ Yes ❑ No Heart Disease _____
❑ Yes ❑ No Asthma/COPD _____
❑ Yes ❑ No Stroke _____
❑ Yes ❑ No Liver Problems _____
❑ Yes ❑ No Blood Clots _____
❑ Yes ❑ No Kidney Problems _____
❑ Yes ❑ No Sleep Apnea _____
❑ Yes ❑ No Other _____

Previous Surgeries:

Surgery/Approximate Date: _____ Surgery/Approximate Date: _____

_____ _____

_____ _____

Please list any of your blood relatives with a history of colon cancer or colon polyps (relation and age):

_____ _____

Previous Endoscopic Procedure Findings:

Colonoscopy _____ Approximate Date: _____

Upper Endoscopy _____ Approximate Date: _____

Do you have a living will? ❑ Yes ❑ No ***Do you have a medical durable power of attorney?*** ❑ Yes ❑ No

Do you want any information regarding these? ❑ Yes ❑ No

_____ _____

Signature ***Date***

Please complete medication form on back page.

8227 W. 20Th STREET
GREELEY, CO 80634

P. (970) 573-7555
WWW.NOCOENDOSCOPY.COM

PATIENT MEDICATION FORM

Allergies or sensitivities to medications or substances (including food, latex, etc.) AND reactions OR ☐ **No Known Allergies**

Medication or Substance	**Reaction (i.e. hives, difficulty breathing)**

Home Medications on Admission (Prescriptions, OTC, Herbs, Vitamins, Supplements, Patches, Inhalers, Etc.)

PLEASE NOTE – WE DO NOT HAVE ACCESS TO OUTSIDE HEALTH RECORDS – YOU MUST FILL THIS OUT OR ATTACH A LIST

Medication and Route	Reason for taking	Dose	Frequency	Last Taken

Verified medication/allergy list with patient pre-procedure: (RN initials) _____

Above is a list of medications that you indicated you are currently taking. Unless otherwise noted, you should resume taking these medications. Please contact the physician who prescribed your medications if you have any questions. Medication prescribed as a result of your visit has been noted below as well. Your signature below means that you understand these instructions.

DO NOT COMPLETE ANYTHING BELOW THE LINE. THIS IS FOR CLINIC STAFF ONLY.

New Medications / Previous Medications with changes

Medication / Reason	Dose	Route	Frequency	Indications/Instructions	Last Dose

Medications given on date of procedure:

Pre-procedure:

☐ No medications
☐ Zofran for Nausea
☐ Other medications: _____

After procedure:

☐ No medications
☐ Zofran for Nausea
☐ Other medications: _____

During procedure:

☐ No medications
☐ Propofol for sedation
☐ Fentanyl for sedation or discomfort
☐ Versed for sedation
☐ Zofran for nausea
☐ Other Medications: _____
_____

Patient/Responsible Party Signature _____

Reviewed and copy sent with patient/responsible party: Date_____ **RN Initials** _____

SIGMOIDOSCOPY CONSENT FORM

CONSENT FOR PROCEDURE

NORTHERN COLORADO ENDOSCOPY CENTER

Patient: _____

1. PROCEDURE AND ALTERNATIVES: I, (patient or authorized representative) authorize Dr._____ to perform procedure: **Sigmoidoscopy with possible biopsy and/or polypectomy.**

I understand the reason and BENEFITS for the procedure are: **Examination of the lower colon with possible removal of tissue and/or removal of a polyp for diagnosis.**

Alternatives include: x-rays, Cologuard, Fecal Occult Blood Test or do nothing.

2. RISKS: This authorization is given with the understanding that any procedure involves some risks and hazards. The more common risks include: infection, bleeding, nerve injury, blood clots, heart attack, allergic reactions, aspiration pneumonia and missed lesions. These risks can be serious and possibly fatal. Some significant and substantial risks of this particular procedure include: **BLEEDING OR PERFORATION. IF EITHER OF THESE COMPLICATIONS OCCUR, TREATMENT MAY INCLUDE HOSPITALIZATION, SURGERY OR BLOOD TRANSFUSION.**

3. SEDATION AND ANESTHESIA: The administration of sedation and anesthesia also involves risks, most importantly a rare risk of reaction to medications causing death. I consent to the use of such sedatives or anesthetics as may be considered necessary by the person responsible for these services.

4. RESUSCITATION: I desire all resuscitative measures be employed during the procedure.

5. ADDITIONAL PROCEDURES: If my physician discover a different, unsuspected condition at the time of the procedure, I authorize the physician to perform such treatment as deemed necessary to improve health.

6. I understand that no guarantee or assurance has been made as to the results of the procedure and that it may not cure the condition.

7. I consent to the photographing of the procedure to be performed for medical purposes.

8. I consent to the admittance of medical or paramedical observers to the procedure room.

9. I hereby request and authorize this health care facility to preserve for scientific or teaching purposes or otherwise dispose of the removed tissue resulting from the procedure authorized above. I further authorize the pathologist, whose services may be required, to use discretion in the disposal.

NOTE: IF YOU HAVE ANY QUESTIONS ABOUT THE PROCEDURE, OR THE RISKS OR CONSEQUENCES ASSOCIATED WITH IT, TALK WITH YOUR PHYSICIAN, YOU MAY WITHDRAW THE CONSENT FOR THIS PROCEDURE AT ANY TIME PRIOR TO ITS PERFORMANCE. DO NOT SIGN THIS CONSENT UNLESS YOU HAVE READ AND THROUGHLY UNDERSTAND THIS FORM.

WHAT TO EXPECT AFTER YOUR SIGMOIDOSCOPY

Dear Patient:

Please follow these guidelines to ensure the best possible outcome after your procedure:

- ❑ Resume medications when you start eating, unless otherwise instructed.
- ❑ Mild bloating is normal. Discomfort can be relieved by walking or lying on your stomach.
- ❑ If a polyp is removed, you must remain in this area or an area easily accessible to emergency health care for 14 days.
- ❑ If biopsies are taken you will be contacted with results within 1-2 weeks.
- ❑ You may have a small amount of blood on the toilet paper or in the stool after bowel movements. If you pass large amounts of blood or blood clots, call us at 970-573-7555 immediately, and at any time of day or night, or go to the nearest emergency department.
- ❑ You should call us at 970-378-1414 immediately, and at any time of day or night, if you have a fever or persistent abdominal, back or chest pains, shortness of breath, or any concerns.

If you receive sedation:

- ❑ Do not drive, operate hazardous machinery, or make critical legal decisions for at least 12 hours.
- ❑ You should be in the presence of an adult for 4-6 hours after your procedure.

NOTICE OF PATIENT RIGHTS & RESPONSIBILITIES

PATIENT RIGHTS

Decision Making

You or your representative have the right to:

- Be informed before care is given or discontinued whenever possible.
- Receive accurate and current information regarding your health status in terms you can understand.
- Participate in planning for your treatment, care and discharge recommendations.
- Receive an explanation of proposed procedures or treatments, including risks, serious side effects and treatment alternatives, including request for second opinion.
- Participate in managing your pain effectively.
- Receive emergency care or transfer to a higher level of care (hospital), if necessary, with a full explanation of your medical need for transfer. No wait for insurance authorization will be required and no financial penalty will be imposed.
- Have persons of your choice promptly notified of hospital admission.
- Accept, refuse or discontinue a treatment or drug, to the extent permitted by law, and be informed of the consequences of such refusal.
- Accept, refuse or withdraw from clinical research.
- Accept, refuse or withdraw from diagnostic or therapeutic procedures.
- Choose or change your healthcare provider.

Equality of Care

You have the right to:

- Respectful treatment, which recognizes and maintains your dignity and personal values without discrimination on the basis of race, color, national origin, sex, age or disability.
- Accurate information about the facility where services are received and the name, credentials and job function of health care personnel involved in your care.
- Interpreters and/or special equipment to assist with language needs.
- Information on how to obtain auxiliary aids or services should these be required.
- Information about continuing healthcare requirements following discharge, including how to access care after hours.

Confidentiality and Privacy

You have the right to:

- Personal privacy and care in a safe setting free from abuse, harassment, discrimination or reprisal.
- Sharing of personal information only among those who are involved in your care.
- Confidentiality of your medical and billing records.
- Notification of privacy practices.
- Notification of breach of unsecured personal health information.

Grievance Process

You, or your representative, have the right to:

- Fair and objective review of any complaint you have regarding care received from healthcare providers/personnel, without fear of reprisal.
- Submit a formal complaint either verbally or in writing as shown below. You will receive a written notice of decision within 15 business days from the date the complaint was made known to the Center.

Administrator of ASC serving as Compliance Officer: 970-573-7555

Colorado Department of Health: 303-692-2904 or email: hfdintake@cdphe.state.co.us

Department of Registry Agency: 303-894-7800 or http://www.dora.state.co.us/medical/complaints.html

CMS Ombudsman: 1-800-MEDICARE (1-800-633-4227) or http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

Office of Inspector General: 800-447-8477 or https://www.oig.hhs.gov/hotlineoperations, or US Department of Health & Human Services, Attn: OIG Hotline Operations, P.O.BOX 23489, Washington D.C. 20026

Office of Civil Rights: https://www2.ed.gov/about/offices/list/ocr/docs/howto.html

Advance Directives
You have the right to know that:
- You may provide a Living Will and/or Medical Power of Attorney.
- It is Northern Colorado Endoscopy Center's policy, regardless of the contents of any advance directive or instructions from a healthcare surrogate, that if a life threatening condition should occur during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you via ambulance to an acute care hospital for further evaluation.

Access to Medical Records
You have the right to:
- Speak privately with health care providers knowing that your health care information is secure.
- Review and/or receive a copy of your Medical Records (including electronic format), within 30 days by secure transmission, upon written request.

Seclusion and Restraints
You have the right to:
- Be free from seclusion or restraint for behavioral management unless medically necessary to protect your physical safety or the safety of others.

Billing
You have the right to:
- Information specific to fees for services and payment policies, prior to the date of service.
- Payment privacy when you choose to opt out of insurance coverage, in accordance with federal regulations.

PATIENT RESPONSIBILITIES

Providing Information
You have the responsibility to:
- Provide accurate and complete information about present problems, past illnesses, hospitalizations, current use of prescribed or OTC medications, current use of nutritional supplemental products, and other health-related matters.
- Report perceived risks in your care and unexpected changes in your condition.
- Provide an Advance Directive, if you have one.
- Provide accurate and updated demographic and contact information for insurance and billing.

Involvement
You have the responsibility to:
- Participate in your plan of care and follow the recommended treatment plan.
- Ensure you have a designated responsible adult to provide transportation and assist with your care for 4-6 hours after your procedure.

Respect and Consideration
You have the responsibility to:
- Act in a respectful and considerate manner toward healthcare providers, other patients, and visitors; physical or verbal threats or conduct, which are disruptive to business operations, will not be tolerated.
- Be respectful of the possessions or property of others, as well as the facility property.
- Assist in keeping noise levels and the number of visitors to a minimum.

Insurance Billing
You have the responsibility to:
- Know the extent of your insurance coverage.
- Know your insurance requirements including pre-authorization, deductibles and co-payments. Deductible amounts owed and copayments are expected at time of service.
- Call the billing office with questions or concerns regarding your bill.
- Fulfill your financial obligations as promptly as possible.

Your physician may have a financial ownership stake in Northern Colorado Endoscopy Center.

Northern Colorado Endoscopy Center

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal law governing the privacy of individually identifiable health information. We are required by HIPAA to notify you of the availability of our Notice of Privacy Practices. This notice describes our privacy practices, legal duties and your rights concerning your Protected Health Information (PHI) and includes provisions outlined in the 2013 HIPAA Final Omnibus Rule.

Your Protected Health Information
We may collect, use and share your PHI for the following reasons:

For payment: We use and share PHI to manage your account or benefits and to obtain reimbursement for the health care services we provide.

For health care operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you receive.

For treatment activities: We use and share PHI to ensure you receive the treatment you need.

To you: We must give you access to your own PHI. We may send you reminders about required follow-up care.

To others: You may tell us in writing that it is okay for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is okay, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is okay, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents). PHI can also be shared with organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be used to report certain information to the U.S. Food & Drug Administration about medical devices that break or malfunction.

Authorization: We will obtain permission from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may withdraw your authorization, in writing, at any time. We will then stop using your PHI for that purpose. If we have already used or shared your PHI based on your authorization, we cannot undo any actions we took before you told us to stop.

How We Protect Information
We are dedicated to protecting your PHI and have set up a number of policies and practices to make sure your PHI is kept secure.

We keep your oral, written and electronic PHI safe using physical, electronic and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to perform their job. Employees are also required to wear ID badges to help keep people who do not belong out of areas where sensitive data is kept.

Your Rights: You may:

- Receive a copy of this Notice of Privacy Practices
- Request limits on disclosure of your PHI
- Receive access to view some or all of your medical record
- Receive a paper or electronic copy of your medical record within 30 days of your documented request
- Request an amendment to your PHI
- Expect your record to be amended within 60 days of your request
- Restrict disclosure of PHI to a health plan when you pay in full at the time of service
- Receive a record of how we have used and/or shared your health information
- Receive information on how to file a complaint if you feel your privacy has been violated
- Opt out of fundraising efforts (when applicable)

We will:

- Not sell your PHI
- Notify you in the event of a breach of your PHI

Contact for further information concerning our privacy practices: You may contact the Privacy Officer at (970) 573-7555.
Complaints: If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health & Human Services. We will not take action against you for filing a complaint.

Rev. 03/2020

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ATTENTION:
If you speak one of the following languages, assistance is available to you free of charge. Please ask for assistance from a staff member.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Pida asistencia de un empleado.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます

Cushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama

Persian (Farsi): **توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با

Ibo: Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na