SOUTH SUBURBAN GASTROENTEROLOGY, PC
WEYMOUTH ENDOSCOPY, LLC

1085 MAIN STREET ~ SOUTH WEYMOUTH, MA 02190
TEL: 781-331-2922 FAX: 781-335-5702
WEB SITE: WWW.SSUBGASTRO.COM

Dear Patient,

This packet is being mailed to you, per recommendation from your Gastroenterologist, that you are due for a follow up colonoscopy and/ or endoscopy procedure.

Thank you for choosing South Suburban Gastroenterology/ Weymouth Endoscopy for your procedure. Enclosed are the forms required in order to schedule your procedure. Please complete the packet and return it to our office. **Once we have received your completed forms we will schedule your procedure**.

Once you are scheduled for your procedure, we will mail out your assigned date & time along with your prep instructions. Please review the instructions at least one week prior to your procedure. You may purchase your prep at your local pharmacy.

If you have any questions please call us at 781-331-2922 or visit our web site at www.ssubgastro.com. We look forward to providing you with the highest quality of care.

Sincerely,

The Physicians of South Suburban Gastroenterology

Dr. Gregory Bolduc
Dr. Bradford Sampson
Dr. Thomas Kenney
Dr. Christopher Kenney
Dr. Brian Gill
Dr. Jonathan Nass

Please return this packet by mail: 1085 Main Street. S. Weymouth, Ma 02190
fax: 781-335-5702 or
email: mary@weymouthendoscopy.com

SOUTH SUBURBAN GASTROENTEROLOGY, PC
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PATIENT INFORMATION

NAME:______________________________ DATE OF BIRTH:_________________

STREET:_____________________________ ***Height**_________ ***Weight**__________ ***BMI**_________

CITY:_____________________ STATE:______ ZIP:__________________________

MAIDEN NAME:_____________________ MARITAL STATUS: M__S__D__W__

SPOUSES NAME:___________________ EMPLOYER:______________________

HOME TEL:______________CELL TEL:_________________WORK TEL:___________________

Please check all that apply:

□ It is OK to leave results from labs, tests and biopsies on my answering machine at my home/cell phone.

□ You can share results of labs, imaging tests, and biopsies with the following people:

____

ALLERGIES: ____

♦♦♦

PRIMARY CARE MD:__________________ REFERRING MD:______________________________

PRIMARY INSURANCE:__________________MEMBER ID #:_____________________________

SUBSCRIBER:______________ DOB:______________EMPLOYER:___________________________

SECONDARY INSURANCE:__________________MEMBER ID #:__________________________

I hereby authorize South Suburban Gastroenterology and/or Weymouth Endoscopy to furnish information to insurance carriers concerning my illness and treatment; and I hereby assign to the physicians all payments for medical services rendered to my dependents and/or myself. I understand that I am responsible for any amount not covered by insurance.

*Are you presently on Wegovy, Ozempic,Mounjaro, Trulicity, Rybelsus or Zepbound: Yes______ No_______
If yes, once your procedure date is scheduled, we will ask you to stop this medication 7 days prior *

Email:____

_____________________________ _____________________________

SIGNATURE DATE

PATIENT HISTORY FORM REVIEW OF SYSTEMS

Name: _____ Date of Birth: _____

Constitutional		
Recent Weight Change	___YES	___NO
Fever	___YES	___NO
Fatigue	___YES	___NO
Eyes		
Blurred Vision	___YES	___NO
Glaucoma	___YES	___NO
Ears/Nose/Mouth/Throat		
Hearing Loss	___YES	___NO
Ringing in Ears	___YES	___NO
Mouth Sores	___YES	___NO
Cardiovascular		
Chest Pain	___YES	___NO
Shortness of Breath	___YES	___NO
Swelling of Ankles	___YES	___NO
Respiratory		
Chronic Cough	___YES	___NO
Spitting up Blood	___YES	___NO
Wheezing	___YES	___NO
Genitourinary		
Burning with Urination	___YES	___NO
Blood in Urine	___YES	___NO
Musculoskeletal		
Joint Pain	___YES	___NO
Swelling	___YES	___NO
Back Pain	___YES	___NO
Muscle Pain	___YES	___NO
Skin		
Rash	___YES	___NO
Itching	___YES	___NO

Gastrointestinal		
Poor Appetite	___YES	___NO
Difficulty in Swallowing	___YES	___NO
Heartburn	___YES	___NO
Nausea	___YES	___NO
Vomiting	___YES	___NO
Bloating	___YES	___NO
Belching	___YES	___NO
Regurgitation	___YES	___NO
Constipation	___YES	___NO
Diarrhea	___YES	___NO
Abdominal Pain	___YES	___NO
Recent Change in Bowel Habits	___YES	___NO
Rectal Bleeding	___YES	___NO
Black, Tarry Stools	___YES	___NO
Neurological		
Headaches	___YES	___NO
Seizures	___YES	___NO
Numbness	___YES	___NO
Strokes	___YES	___NO
Psychiatric		
Memory Loss or Confusion	___YES	___NO
Depression	___YES	___NO
Endocrine		
Heat Intolerance	___YES	___NO
Cold Intolerance	___YES	___NO
Excessive Thirst	___YES	___NO
Excessive Urination	___YES	___NO
Hematological		
Bleeding Tendency	___YES	___NO
Bruising Tendency	___YES	___NO
Anemia	___YES	___NO
Past Transfusion	___YES	___NO
Are you Pregnant?	___YES	___NO

Do you take any blood thinners? No ☐ Yes ☐ What Medication _____

If yes who is the prescribing doctor? _____

Medication Allergies: _____

List of Medications and Doses:

_____

_____

_____

PATIENT HISTORY FORM

Name _____ Date of Birth _____
Language: _____ Height: _____ Weight: _____ ** BMI _____ **
Primary Care Physician: _____ Pharmacy: _____ Location: _____
Reason for today's visit: _____
List all prior surgeries and date: _____
_____

Circle Present and Past Medical History:
Hypertension Heart Attack Angina Arrhythmia Congestive Heart Failure Heart Murmur Elevated Cholesterol Diabetes Anemia Arthritis Blood Clot in Leg or Lung Seizure Stroke Hepatitis Tuberculosis Cancer Asthma Bronchitis Emphysema Rheumatic Fever Thyroid Disease Peptic Ulcer Hiatal Hernia Ulcerative Colitis Crohn's Disease Irritable Bowel Syndrome Sleep Apnea Anxiety/Depression Reflux Constipation
Other: _____

Have you ever had a colonoscopy before?
☐ No ☐ Yes
If so, when and where? _____

Have you ever had any problems with anesthesia or sedation? ☐ No ☐ Yes
If yes, what happened? _____

Have you ever smoked? ☐ No ☐ Yes
If currently smoking, how many packs per day? _____
If not currently smoking, quit date: _____
Do you drink alcohol? ☐None ☐Occasional ☐Daily
Recreational drug use? ☐ No ☐ Yes
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐Widowed
Do you work? ☐ No ☐ Yes Type of Work: _____

Any family history of liver disease, celiac disease, Crohn's, ulcerative colitis, other cancer? _____
Colon Polyps: ☐ No ☐ Yes Whom: _____
Colon Cancer: ☐ No ☐ Yes Whom: _____
Other Significant Disease(s): _____

To Be Completed by Gastroenterologist on day of exam:

HPI: _____
_____
_____
_____
_____
_____

Physical Examination: BP_____ Hgt_____Wgt_____	**Yes**	**No**	**Comments**
1. Constitutional: Well-nourished/well developed:	☐	☐	_____
2. Skin: Skin free of rashes, purpura, petechiae, stigmata:	☐	☐	_____
3. Eyes: Lids and Conjunctivae normal:	☐	☐	_____
4. Ears/Nose/Mouth/Throat: Is the oral mucosa pink/moist	☐	☐	_____
5. Hematologic/Lymphatic/Immunologic: Nodes in neck nl:	☐	☐	_____
6. Respiratory: Lungs clear to auscultation:	☐	☐	_____
7. Cardiovascular: Heart rate regular & no murmur:	☐	☐	_____
8. Gastrointestinal: Soft, nl tympany, active bs, no hsm no masses, no tenderness	☐	☐	_____
9. Musculoskeletal: No clubbing, deformities, edema of extremities	☐	☐	_____
10. Rectal: Hem occult negative:	☐	☐	_____
11. Neurologic: Intact	☐	☐	_____
12. Psychiatric: Alert, oriented to time/person/place	☐	☐	_____

Reviewed By _____ Date: _____
ASA: _____
I have reassessed the patient and find no changes to the above
Reviewed By: _____ Date: _____

WEYMOUTH ENDOSCOPY, LLC

PATIENT MEDICATION HISTORY FORM

Name: _____ Date of Birth: _____

Date of Exam: _____

Allergies / Sensitivities and Reactions:

_____

_____

Name of Medication/Vitamin/OTC	Dose	How often taken	Last dose taken
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Physician Documentation:

Any changes to medication after procedure: **No** ☐ **Yes** ☐ _____

New medication added today: **No** ☐ **Yes** ☐ _____

	N/A	Yes	Number of Days
Hold Aspirin	☐	☐	_____
Hold Ibuprofen, Aleve, Excedrin	☐	☐	_____
Hold Blood Thinners	☐	☐	_____

☐ Due to your endoscopic intervention, please refrain from Aspirin and NSAID products for _____ days

MD signature: _____ Date: _____

Nursing Documentation: Today you had the following procedure:
Colonoscopy ____ Gastroscopy____ Flexible Sigmoidoscopy____

You were given the following medications: Propofol __ Fentanyl __ Versed __ Zofran __
Lidocaine____ Glycopyrrolate____ Other _____

Endoclip was used today Yes - If yes and you require an MRI in the next month, please notify the Radiologist.

Nurse Signature: _____ Date: _____

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TEL: 781-331-2922 FAX: 781-335-5702

INSURANCE WAIVER OF LIABILITY

Without a referral, your insurance may not pay for services rendered. If your insurance determines that a particular service is not covered without a referral, your insurance may deny payment for that service.

As your physician, I believe this service is medically necessary, but it may not be payable under your insurance policy. In this specific circumstance, your insurance may deny payment for this service.

♦♦

I have been informed by my physician's office that I am responsible for payment of this service should my insurance company deny payment.

____ ____________________
Signature Date

WEYMOUTH ENDOSCOPY, LLC.

CONSENT FOR COLONOSCOPY

My physician has recommended a Colonoscopy to evaluate the following condition:

_____

1. **CONDITION**

My physician has explained to me the technique of Colonoscopy, the risks and benefits of Colonoscopy, additional procedures, which may be performed during Colonoscopy and the way in which I will be sedated for my Colonoscopy. I have had an opportunity to ask any questions, discuss alternative therapies, risk and benefits and I have received appropriate responses to these questions.

2. PROCEDURE: DESCRIPTION OF COLONOSCOPY

Colonoscopy is an examination of the Colon, using a flexible scope, which will be inserted into the rectum and advanced under visual guidance throughout the entire length of the colon to its junction with the small intestine into the cecum and sometimes into the small intestine. During Colonoscopy, an image of the inside lining of the colon is portrayed on a video monitor and reviewed by my physician. This technique allows the physician a detailed examination of the lining of the bowel where pathology is most likely to occur. This technique has the ability to diagnose most of the common diseases of the colon and to exclude those diagnoses, which are of the greatest concern. Any tissue removed during Colonoscopy will be sent to a pathology laboratory where a Pathologist will review it. A colonoscopy is an imperfect exam and there is a small but real possibility that significant pathology including polyps and small cancers may be missed.

ADDITIONAL PROCEDURES:

Additional procedures are commonly performed during Colonoscopy, which include biopsies of the lining of the large bowel, Polypectomy, which is the removal of polyps and cautery of abnormal blood vessels. Sometimes dilation of stricture or tattoo of lesion site is required. These procedures are performed routinely in Colonoscopy if the appropriate pathology is identified during that examination.

3. RISKS AND BENEFITS

RISKS OF COLONOSCOPY:

The risks of Colonoscopy are rare, but may be serious and life threatening. These risks include perforation of the colon by the colonoscope, which usually requires surgical repair. It is possible that a Colostomy may need to be performed during the repair of a perforation. Additional risks include bleeding, which is most likely to occur after removal of a polyp. Bleeding is usually self-limited, but may be serious and can possibly require transfusions and/or surgery to control. Infections, leakage of air from the bowel into the abdominal cavity are also possible complications. Additional risks associated with any invasive procedure, but not specifically associated with Colonoscopy include unanticipated bleeding, development of blood clots, tissue damage, respiratory problems, infections, and cardiovascular or pulmonary complications. There is a risk of infection transmission related to entering a medical facility and undergoing a medical procedure during the current pandemic.**I understand that do not resuscitate directives will not be honored at this facility.**

SEDATION:

During Colonoscopy I will receive intravenous medicine for sedation. This technique may use several different medications alone or in combination, which result in the induction of a sleep like state, during which memory is often impaired. The degree of sedation varies from person to person and it is conceivable that some pain may be felt during the procedure or some discomfort remembered after the procedure. My physician is limited in the amount of medicine that can be administered by safety factors and changes in my vital signs. Complications from sedation include: Inadequate Respiration, which may require respiratory assistance or reversal of the sedative, low blood pressure, erratic or slow pulse rate, all of which may require administration of additional medications.

4. ACKNOWLEDGEMENT

I understand the need for Colonoscopy. I understand the potential benefit of the procedure and the potential risks associated with it.

5. CONSENT

I give my consent to have the procedure performed by Dr. _____.

_____ _____

Patient/Legal Representative Witness

_____MD _____