GI Health Hawaii
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Gastroenterology

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NAME : _____

Colonoscopy TWO-DAY EXTENDED Preparation

Please follow the instructions precisely to ensure a successful colonoscopy. ***Incomplete preparation will lead to a repeat of the procedure and additional out-of-pocket patient cost.*** If you need to reschedule, have any questions, or are experiencing difficulties, please call (808)888-0967 Mon-Fri 8:00am-4:00pm. If after office hours or on weekends, please call Physicians Exchange at (808)524-2575 and ask to speak with the Gastroenterologist on call.

DAY OF THE PROCEDURE:

CHECK-IN TIME: PROCEDURE TIME:

LOCATION: ❑ ENDOSCOPY INSTITUTE OF HI 1401 S. BERETANIA ST, **SUITE 200, 2ND FLOOR** (808)312-6700

❑ PACIFIC ENDOSCOPY CENTER 1029 MAKOLU ST, **STE H** (808)456-6420

ONE WEEK BEFORE YOUR PROCEDURE:

❑ Please call 808-888-0967 to review the instructions and address any questions.

☆ **DO NOT eat popcorn, seeds, corn, or nuts.**

☆ ***If you take blood thinners, please STOP _____ on _____.***

****Please do not discontinue your medication until the nurse calls and confirms a clearance was obtained from your cardiologist.****

❑ Confirm you will have a driver to pick you up after the procedure.

- The driver must be 18 years or older and present at your discharge.
- You are REQUIRED to have an adult accompany you to any procedure in which you undergo anesthesia due to the risks and complications that may arise following the procedure.
- If you do not have a driver, we can arrange to call a Medicab through Charley's Taxi at the patient's expense. Please let the staff know at check-in if this service is needed.

☆ **Make sure you pick up your colonoscopy prep kit:**

_____ **Miralax (119g)**

_____ **Gavilyte (1 gallon)**

_____ **Moviprep**

Alternate: _____

☆ **Purchase *Gatorade (32 oz, YELLOW or WHITE; NO RED, ORANGE, PURPLE):**_____

***Petroleum Jelly (i.e. Vaseline or Aquaphor) to minimize anal skin irritation.**

THREE DAYS BEFORE YOUR PROCEDURE:

❏ Stop taking fiber supplements and anti-diarrheal medications.

☆ Eat low-fiber foods. Avoid leafy and stringy fruits or vegetables.

LOW FIBER DIET FOR COLONOSCOPY	
✅ **Foods that are OK**	🚫**Foods to AVOID**
White bread , Tofu	Whole wheat bread or pasta
White rice or noodles	Brown or wild rice
Plain crackers, vanilla wafers	Whole wheat crackers and rolls
Skinless cooked potatoes	Raw or undercooked vegetables
Skinless chicken, turkey, eggs or fish	Tough meat Or meat(with skin)
Canned fruits (no seeds or skin)	Cereals, granola, cornbread

TWO DAYS BEFORE YOUR PROCEDURE:

❑ In the morning, mix your colon preparation with water according to the instructions. Place in the refrigerator to chill. (You must use the solution within 24 hours after mixing.)

☆ You may eat breakfast.

☆ **Start a clear liquid diet after breakfast. NO SOLID FOODS. See Table below.**

❑ If you take blood pressure medications, aspirin or NSAIDS, you may continue to take them as usual unless otherwise instructed by your physician.

☆ ***DIABETIC PATIENTS: No oral medications. INSULIN USERS: take ½ of the usual dose.***

✅ YOU MAY DRINK :	🚫 DO NOT DRINK THESE LIQUIDS
• Gatorade, Crystal Light Lemonade, Pedialyte, or Powerade • Coffee or Tea (Black Only, Sugar OK) • Carbonated or non-carbonated soda • Fruit-flavored drinks • Apple juice, white cranberry juice or white grape juice • Jell-O (gelatin) or popsicles • Broth	• Alcohol • Milk or non-dairy creamer • Juice with pulp • Any liquid you cannot see through • No noodles or vegetables in soup • Hard Candy *****NO RED, ORANGE, OR PURPLE COLORED DRINKS*****

TWO DAYS BEFORE YOUR PROCEDURE:

☆ **START DRINKING THE COLON PREPARATION SOLUTION AT 5:00P.M.**

- Drink one cup of the solution every 15 minutes until HALF the mixture is gone. ***This is the recommended pace. However, if you feel nausea or vomiting, it is perfectly fine to take frequent breaks and drink the solution at your own pace.***
- Stay near a toilet as you will have diarrhea, which may start one to five hours after you drink the solution. This can be sudden and may last two hours or more hours after finishing the solution.
- If there is no bowel movement, do not worry, please continue with the instructions.

☆ Drink water often to avoid dehydration.

☆ Apply petroleum jelly as needed to alleviate anal skin irritation.

ONE DAY BEFORE YOUR PROCEDURE:

❏ In the morning, mix your colon preparation with water according to the instructions. Place in the refrigerator to chill. (You must use the solution within 24 hours after mixing.)

❏ **Continue the Clear Liquid Diet.**

❏ **If you take blood pressure medications, aspirin or NSAIDS, you may continue to take them as usual unless otherwise instructed by your physician.**

☆ ***DIABETIC PATIENTS: No oral medications. INSULIN USERS: take ½ of the usual dose.***

☆ **START DRINKING THE COLON PREPARATION SOLUTION AT 8:00 A.M.**

- Drink one cup of the solution every 15 minutes until HALF the mixture is gone.
- Drink water often to avoid dehydration.
- Apply petroleum jelly as needed to alleviate anal skin irritation.

☆ **DRINK ANOTHER THE COLON PREPARATION SOLUTION AT 5:00P.M.**

- Drink one cup of the solution every 15 minutes until HALF the mixture is gone.
- Drink water often to avoid dehydration.
- Apply petroleum jelly as needed to alleviate anal skin irritation.
- Please do not skip the instructions for the bowel preparation on the day of your colonoscopy due to our body's production of bile overnight.

DAY OF THE PROCEDURE:

CHECK-IN TIME: PROCEDURE TIME:

(*NO SMOKING ON THE DAY OF THE PROCEDURE*)

☆ **On the day of the procedure, at _____, or 5 hours before you leave home for the procedure, drink the colon preparation solution 1 cup every 15 minutes.**

❑ You are ready when your stool is clear or yellow liquid

❑ Apply petroleum jelly as needed to alleviate skin irritation.

☆ Take your morning medications at least 2 hours before you leave for your procedure.

☆ ***DIABETIC PATIENTS ONLY: No oral medications until after the procedure with food. INSULIN USERS: no insulin until after the procedure with food.***

☆ TWO HOURS BEFORE YOUR CHECK-IN TIME: _____

PLEASE STOP **ANY** INTAKE BY MOUTH, INCLUDING WATER, MINT & GUM)

❑ Please leave all jewelry and personal items at home.

❑ Please do not wear contact lenses.

☆ Please wear socks to keep your feet warm.

❑ If you have removable dental wear, a denture cup will be provided.

☆ Please bring your I.D. and insurance cards to your appointment.

❑ Please bring a list of all your current medications, including over-the-counter.

☆ Your facility copayment or co-responsibility will be collected on the date of service unless you made other arrangements. Please bring your preferred form of payment (credit card, check, or cash). **The physician fee and/or pathology fees will be billed separately and sent to the patient after the insurance has processed the claim.**

❑ Expected duration at the Facility will be between 2-3 hours.

☆ Please be aware that there may be unexpected delays from preceding cases.

❑ Though the risk is small, if complications arise, you may be admitted to the hospital for further observations. Complications may include bleeding, perforation, or adverse reaction to the anesthesia.

COLON CLEANSING TIPS:

1. Drink the solution with a straw to make it easier to tolerate.
2. If you experience nausea or vomiting, give yourself a 30 minute break and then try to drink the prep solution again.
3. You may experience cramps until all the stool has flushed from your colon, which may take 2-4 hours or longer.
4. Anal skin irritation or flare of hemorrhoid inflammation may occur. You may use over-the-counter remedies, such as hydrocortisone cream, baby wipes, Vaseline, or TUCKS pads to improve comfort. Avoid products containing alcohol.

☆ **If you develop symptoms such as cold, fever, persistent coughs, or runny nose, please call (808) 888-0967 to reschedule your appointment. The facility will contact you 1-2 days prior to confirm your appointment and to complete a COVD-19 questionnaire.**

MEDICATION LIST:

(*PLEASE COMPLETE THE FORM AND BRING TO THE FACILITY CENTER ON THE DAY OF YOUR PROCEDURE*)

SOURCE OF INFORMATION: _____ PATIENT _____ FAMILY _____ OTHER

ALLERGIES	REACTION	ALLERGIES	REACTION

MEDICATION NAME	DOSE	FREQUENCY	ROUTE	REASON	LAST TAKEN
1.					
2.					
3.					
4.					
5.					
6.					