MIDDLESEX
DIGESTIVE HEALTH & ENDOSCOPY CENTER

45A Discovery Way, Acton MA01720
Phone: 978-429-2000 • Fax: 978-264-1935

Upper Endoscopy Procedure Instructions

*****PLEASE READ ENTIRE PACKET AT LEAST ONE WEEK PRIOR TO YOUR APPOINTMENT*****

Dear Patient,

If you are a new patient, you have received this paperwork in order to set up a procedure.
If you are an existing patient and have received this packet, you are due for a follow-up procedure.

******Please look for an email or text with a link to input your personal and health information. Please fill out at least 5 days prior to your procedure starting approx. 4/25/2025 ******

If you prefer to fill out the attached forms, please complete and attach a copy of your ID and insurance card (front and back) and return these to the center as soon as possible.

PLEASE ALSO BRING YOUR INSURANCE CARD AND A VALID ID WITH YOU ON THE DAY OF YOUR PROCEDURE.

If your insurance requires a referral, please contact your primary care physician to obtain one. You may have a deductible, coinsurance, or copay for your procedure. Please contact your insurance company to review the coverage and costs of your procedure so you are aware of any potential additional expenses. Final determination of patient responsibility is determined when the claim is processed. For procedures, there is a facility fee, professional fee, a possible pathology fee which would be from Gastro Health, Greater Boston GI/Atrius Health, and an anesthesia fee from Greater Boston Anesthesia.

Please call if you have the following conditions (these may require additional instructions for safety):

- **Take an Anticoagulant** (Coumadin/Warfarin/Eliquis/Xarelto/Brillenta), Plavix or Aspirin 325mg
- Had any **recent cardiology concerns and/or cardiac surgery**, cardiac stent placement within the last 12 months or have ever had a cardiac valve replacement and require antibiotics prior to medical procedures
- Have **medication-dependent diabetes** or take a **GLP1 or SGLT2i medication for weight loss or diabetes** (Ozempic, Trulicity, Wegovy, Jardiance, Invokana etc.) read page 8 at least 8 days prior to procedure to avoid possible cancellation.
- Have a history of long QT syndrome, allergy to Zofran (ondansetron), or if you are taking Apokyn (contraindicated with Zofran)
- Have had a recent cold, cough, congestion or diagnosed with Covid-19 within the last 10 days.

Cancellation Policy: A 48-hour advanced notice is needed for cancellations. If you neglect to give 48-hour notice, a ***$150 fee*** will be charged to cover administrative costs. After 2 missed appointments, you will not be rescheduled.

Please arrange a ride home. Due to the effects of anesthesia, you cannot drive yourself home and cannot take a taxi, Uber/Lyft, etc. unless accompanied by a responsible adult. Your ride should be available at all times. The facility closes by 3:30pm so please ensure your ride can accommodate this.

Location: Middlesex Endoscopy Center, 45A Discovery Way Acton, MA 01720 Phone: 978-429-2000
If your procedure is booked at Emerson Hospital, please pre-register there at 978-287-3062.

What To Expect For Your Upper Endoscopy Procedure

BEFORE YOUR PROCEDURE

Preparation: Time-sensitive instructions included. (Must read at least 5 days prior)

Pre-procedure Questionnaire: We are in the process of implementing an electronic intake system. You may receive an email or text asking you to submit your personal information, health history and medications. If you complete this electronically you do not need to fill out the pre-procedure medical form in this packet.

AT YOUR PROCEDURE (Average Total Time at Center 1.5-2.5 Hours)

Check-In: Please arrive 30 min before your procedure time. We will verify personal and insurance information (please bring license and insurance card). We will have you sign facility consents and provide name/number for your ride home.

Pre-Procedure: A nurse will review medical history, current medications and record vital signs. A shirt with a sleeve that can roll up above the elbow can remain on as well as your pants. An intravenous (IV) catheter will be placed for hydration, anesthesia and other medications as needed. You will discuss the procedure risks/benefits and sign consents for the anesthesiologist and the gastroenterologist.

Complications from this procedure are rare. There are slight risks such as bleeding, irritation of the throat, or inflammation of the vein used for the IV medication. Your doctor will explain these and other risks in full and answer any questions you may have before consents are signed.

Procedure: In the procedure room, monitors and oxygen will be set up. The anesthesia provider will administer the medication through the IV once the team is ready to begin. The medication most commonly used is called propofol and causes a light sleep. You are unaware of the procedure but breathing on your own.

An Upper Endoscopy is a diagnostic procedure in which a flexible, lighted tube is inserted through the mouth enabling the physician to directly visualize the interior lining of the esophagus, stomach and duodenum. Biopsies can be performed during the procedure. An upper endoscopy on average takes approximately 5 minutes.

Recovery: Your ride will be notified to arrive. Vital signs will be monitored as you wake up in the recovery area. Once stable, your IV will be removed and then you can get dressed if needed. You will be offered water to drink. You will receive verbal and written discharge instructions and your doctor will review your exam with you before you leave. No driving, drinking alcohol, or recreational drug use on the day of your procedure for safety and anesthesia purposes. Average recovery time is 30 minutes.

Please arrange a ride home. **Due to the effects of anesthesia, you cannot drive yourself home and cannot take a taxi, uber/lyft, etc. unless accompanied by a responsible adult. Your ride should be readily available at all times. Facility closes by 3:30pm.**

Valuables are not the responsibility of the Center
Patients are encouraged to leave all valuables at home to avoid the possibility of loss or theft. Valuables including jewelry, money, computers, dentures, hearing aids, etc.

Please visit our website www.middlesexdigestive.com for more information, as well as directions our facility.

Upper Endoscopy Procedure Instructions

Five Days prior to Procedure:

Stop multivitamins, iron, vitamin E, calcium, NSAIDs (advil, ibuprofen, motrin, aleve, etc.) and aspirin. Baby Aspirin 81mg and Tylenol are ok to continue. If you take an **Anticoagulant, Plavix, Aspirin 325mg, a GLP1 antagonist (ex. Ozempic, Trulicity, Wegovy, etc.)** or an **SGLT2i medication (ex. Jardiance, Invokana etc.)** please call our office 978 429 2010 for further instructions to avoid a possible cancellation.

Night Before Procedure:

Do not eat any solid foods after **midnight.**

Day of Procedure: - - - PLEASE REFRAIN FROM SMOKING PRIOR TO YOUR PROCEDURE

You may drink clear liquids until **4 hours before your procedure.**
See clear liquid diet below. No honey, gum or candy.

You may take your heart and blood pressure medications with a sip of water at least 2 hours prior to your procedure time unless directed otherwise. (For blood thinners please contact our office for instructions). Please bring your inhaler if you have one. No marijuana use on the day of procedure.

HAVE NO SOLID FOODS AFTER MIDNIGHT

NOTHING TO DRINK for 4 HOURS PRIOR TO PROCEDURE

Plan on being with us for **1.5-2.5 hours**. Please arrive 30 min prior to your appointment time.
You are not allowed to drive a vehicle or take a cab/uber/lyft unattended by an adult after your procedure.

If you do not have someone to drive you home, your procedure will be cancelled.
RIDES MUST BE READILY AVAILABLE AT ALL TIMES. FACILITY CLOSES AT 3:30PM.

CLEAR LIQUID DIET

YES – OK To Have	NO – Avoid These
Water, Gatorade or clear sports drinks Apple juice, white grape juice, white cranberry juice Limeade or lemonade Black coffee or black tea (sugar only ok) Chicken or Beef Broth Gelatin without toppings (no red, blue, purple)	Milk, Cream or Honey Any red, blue, purple liquids Orange or tomato juice Cream soups-Any soup other than clear broth Oatmeal or cream of wheat Any alcohol

Middlesex Digestive Health and Endoscopy Center
Pre-Procedure Medical Form

Name: _____ Date of Birth: _____
Height:_____ Weight:_____
Ethnicity:_____ Primary Language:_____
Are you hearing impaired: Yes \ No
Do you request for an interpreter/translator?: Yes / No
If yes, please circle for: speech / hearing / written material

Do you have a history of:

Cardiac Problems:

Yes No

- ☐ ☐ High Blood Pressure
- ☐ ☐ Valve Replacement- Date of surgery: _____
- ☐ ☐ Arrythmia / AFib / Heart Murmur / Palpitations
- ☐ ☐ Angina/Heart Attack (MI) : Date of: _____
- ☐ ☐ Pacemaker: Date of surgery/checked:_____
- ☐ ☐ Defibrillator (AICD)- call our office
- ☐ ☐ CABG, Bypass, Angioplasty: Date of: _____
- ☐ ☐ Swelling of extremities/edema
- ☐ ☐ High Cholesterol

Respiratory Problems:

Yes No

- ☐ ☐ Asthma, COPD, Emphysema, Other:_____
- ☐ ☐ Sleep Apnea: Do you use a cpap?: Yes No
- ☐ ☐ Difficult airway / history of tracheotomy- call office

GI Problems:

Yes No

- ☐ ☐ Family History of Colon Cancer Relationship: _____
- ☐ ☐ Family History of Colon Polyps Relationship: _____
- ☐ ☐ Family History of Crohns Disease/Ulcerative Colitis? Relationship: _____
- ☐ ☐ Personal History of Colon Cancer
- ☐ ☐ Personal History of Polyps
- ☐ ☐ Diverticulosis and/or Diverticulitis
- ☐ ☐ Crohns Disease, Colitis, or Celiac Disease
- ☐ ☐ Irritable Bowel Syndrome
- ☐ ☐ Bleeding
- ☐ ☐ Constipation or Diarrhea
- ☐ ☐ Stomach or Esophageal Ulcers
- ☐ ☐ Barretts Disease, History of Eosinophilic Esophagitis
- ☐ ☐ Weight Loss/Nausea/Vomiting

Liver/ Gallbladder Problems:

Yes No

- ☐ ☐ Hepatitis A B C
- ☐ ☐ Cirrosis/Liver Disease
- ☐ ☐ Gallbladder Disease/ Surgery

For nursing use only:

R:_____

Cls:_____ Pa: _____

Egd: _____ F: _____

P: _____ Zofran:_____ S:_____

Npo: _____ A: _____

Endocrine Problems:

Yes No

- ☐ ☐ Diabetes- Insulin Oral Diet
- ☐ ☐ Thyroid Problems: _____

Kidney/Prostate Problems:

Yes No

- ☐ ☐ Kidney Disease

Men Only:

- ☐ ☐ Prostate CA
- ☐ ☐ Prostate Enlargement/ BPH

Neurological problems:

Yes No

- ☐ ☐ Stroke
- ☐ ☐ Seizure
- ☐ ☐ Headache/Migraine
- ☐ ☐ Transient Ischemic Attack (TIA)
- ☐ ☐ Vertigo/Balance Issues/ Dizziness

Orthopedic/Musculoskeletal Problems

Yes No

- ☐ ☐ Arthritis
- ☐ ☐ Joint Replacement: _____

Mental Status:

Yes No

- ☐ ☐ Depression
- ☐ ☐ Anxiety/ Panic Disorders
- ☐ ☐ Confusion

Blood Disorders:

Yes No

- ☐ ☐ Anemia
- ☐ ☐ Clotting Disorders/or Anticoagulant use
- ☐ ☐ Bruises easily

Women Only:

Yes No

- ☐ ☐ Hysterectomy
- ☐ ☐ Mastectomy/ Lumpectomy: R L
- ☐ ☐ Are you pregnant? LMP: _____

Do you have a history of Cancer? ☐ **Yes** ☐ **No**

Type: _____

Treatment:_____

Name: _____

Primary Care Physician:_____

Primary Care Physician Address: _____

Social History:

Yes No

- ☐ ☐ Recreational Drug use: Amt: _____
- ☐ ☐ Alcohol Use: Amt: _____
- ☐ ☐ Smoker: Amt: _____

Any Metal inside your body/ Aides?

Yes No

- ☐ ☐ Metal pins/rods/plates?
  Location: _____
- ☐ ☐ Dentures: Full?: U L Partial: U L
- ☐ ☐ Hearing Aid: R L - Are they in place?: Yes No

PLEASE LIST YOUR SURGICAL HISTORY AND ANY OTHER MEDICAL HISTORY:

_____

_____

_____

1.) Do you have a history of requiring antibiotics prior to dental work or medical procedures? YES NO
2.) Do you have a healthcare proxy? If yes please bring a copy to your procedure if available. YES NO
3.) May we leave a message on your home or work answering machine regarding your care? YES NO

ALLERGIES (please list any allergies and the reactions you experienced)

Food Allergy?: Yes No Please list:_____

Medication Allergy?: Yes No Please list: _____

_____

Adhesive Sensitivity: Yes No **Egg allergy**:Yes No **Iodine allergy:** Yes No **Latex Allergy:** Yes No

PLEASE LIST ALL OF YOUR MEDICATIONS/VITAMINS (prescriptions and over the counter)

MEDICATION	DOSEAGE	FREQUENCY	LAST DOSE
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____
5._____	_____	_____	_____
6._____	_____	_____	_____
7._____	_____	_____	_____
8._____	_____	_____	_____
9._____	_____	_____	_____
10._____	_____	_____	_____
11._____	_____	_____	_____

Did you take Zofran Prior to your procedure? Yes No _____

This information has been reviewed and updates with the patient just prior to the procedure. Updated 10/7/2022

Gastro Health, P.C./ Middlesex Endoscopy Center LLC.

Consent to Disclose Health Information for Payment, Treatment, and Health Care Operations

These records will be transferred to Electronic Medical Records through Emerson Hospital

Patient Name: _____
Last First Middle

Home Address:_____
Street Town State Zip

Date of Birth:_____ **Gender**:_____

Home Telephone:_____ **Cellular Telephone**:_____

Emergency Contact:_____ **Relationship to Patient**:_____

Emergency Contact Telephone:_____ **For Tricare – Sponsor's SSN**:_____

Email address:_____****provide e-mail address if you would like **Emerson Portal** access

Primary Insurance: _____ **Primary Care Physician**:_____

Secondary (If any): _____

How would you like to receive reminders? (circle one) Text Phone Call or Email

***Are we authorized to discuss your appointments, test results, and other pertinent health information with another person?(i.e. spouse, sibling, parent) **Yes** **No**

☐ ☐

If yes, who: _____ Relationship to patient: _____

Acknowledgment of Receipt of Practice's Notice of Privacy Practices:

By my signature below, I hereby acknowledge that I have received a copy of the Practice's Notice of Privacy Practices.

Consent to Disclose My General Health Information:

By my signature below, I hereby authorize the Practice to disclose my medical information so that the Practice may treat me, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations (e.g., quality assurance). I also authorize the Practice to disclose my medical information to insurers and providers outside of the Practice when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care operations. I also understand that my refusal to sign this consent or revoking this consent may lead to refusal of treatment as permitted by Section 164.506 of the Code of Federal Regulations.

_____ _____

Signature of Patient Date

If the patient is an unemancipated minor or otherwise incapacitated (physically or mentally), obtain the following signatures:

_____ _____ _____

Signature of Personal Representative Description of Authority Date

***For Office use only: ID (License has been checked) ☐ ***

PLEASE ENCLOSE A COPY OF YOUR INSURANCE CARD

In order to protect your identity we request that you bring a valid picture ID and your insurance card to your visit.

MIDDLESEX ENDOSCOPY CENTER, LLC 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 it carefully.

Patient Health Information Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information. Your information may be stored electronically and if so is subject to electronic disclosure.

How We Use & Disclose Your Patient Health Information Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care. Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment or disclose your information to payors to determine whether you are enrolled or eligible for benefits. We will submit bills and maintain records of payments from your health plan. Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, arranging for legal services and to assess the care and outcomes of your case and others like it. Special Uses and Disclosures Following a procedure, we will disclose your discharge instructions and information related to your care to the individual who is driving you home from the center or who is otherwise identified as assisting in your post- procedure care. We may also disclose relevant health information to a family member, friend or others involved in your care or payment for your care and disclose information to those assisting in disaster relief efforts. Other Uses and Disclosures We may be required or permitted to use or disclose the information even without your permission as described below: Required by Law: We may be required by law to disclose your information, such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events. Research: We may use or disclose information for approved medical research. Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities. Health oversight: We may disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena, discovery request or court order. Law enforcement purposes: We may disclose information needed or requested by law enforcement officials or to report a crime on our premises. Deaths: We may disclose information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies. Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes. Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work- related injuries or illness. Business Associates: We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information. Messages: We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods. In any other situation, we will ask for your written authorization before using or disclosing identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization. Individual Rights You have the following rights with regard to your health information. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights. You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by the request and when the uses or disclosures are not required by law. You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

1. In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for copies.
2. You have the right to request that we amend your information.
3. You may request a list of disclosures of information about you for reasons other than treatment, payment, or health care operations and except for other exceptions.
4. You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

Our Legal Duty- We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured protected health information.

Changes in Privacy Practices- We may change this Notice at any time and make the new terms effective for all health information we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the person listed below.

Complaints- If you are concerned that we have violated your privacy rights, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Marie Russell RN- Center Leader
Middlesex Endoscopy Center, LLC
45A Discovery Way
Acton, MA 01720

Please read the following if you take medications for Weight Loss or Diabetes:

GLP1 and SGLT2i Medication Guidelines

If you take a GLP-1 medication (injectable or oral) and/or a SGLT2i medication, please follow the protocol below. Otherwise, your procedure may be rescheduled or cancelled due to anesthesia concerns.

Weekly GLP-1 injectables need to be held 8 days prior to procedure.

Examples: Ozempic(Semaglutide) , Wegovy (Semaglutide), Mounjaro (tirzepatide), Trulicity (Dulaglutide), Bydureon(Exenatide), Tanzeum (albiglutide), Zepbound (tirzepatide) etc.

Daily GLP-1 medications need to be held 4 days prior to procedure.

Examples: Rybelsus (Semaglutide), Victoza(liraglutide), Saxenda (liraglutide), Byetta (exenatide), Adlyxin (lixisenatide) etc.

Daily SGLT2i medications need to be held 4 days prior to procedure.

Examples: Jardiance (empagliflozin), Invokana (canagliflozin), Farxiga (dapagliflozin) Steglatro (ertugliflozin), Brenzavvy (bexagliflozin), Inpefaetc (sotagliflozin) etc.

IF YOU TAKE 2 OR MORE MEDICATIONS FOR DIABETES PLEASE REACH OUT TO YOUR PCP OR ENDOCRINOLOGIST FOR FURTHER INSTRUCTIONS.