Welcome to Charles River Endoscopy, LLC.
Please read all instructions prior to your procedure.
There will be a $100.00 charge if you cancel your procedure within 72hrs. All double procedures will be $200.00.
(payable to Charles River Endoscopy, LLC)

- On the day of procedure bring your photo ID, insurance card, and 3 completed pages of personal information included in the packet sent from GastroHealth.
- No solid food on the day before your colonoscopy.
- Only clear liquids the day of your procedure
  - No broth or Jello on day of procedure
  - If you take a GLP-1 for diabetes or weight loss no solid food day before procedure or it will be cancelled. If you use Phentermine you must be off that medication for one week prior to procedure.
- Absolutely nothing to drink for 4 hours prior to procedure. This may cause a **cancellation** of your procedure.
- Your ride MUST be here to pick you up within one hour of the scheduled procedure time. **No exceptions.**
  - For all 7:30, 8:00, 2:00, and 2:30 appointments; the ride must wait in our waiting room.
- For your safety, **NO** Ubers, taxis, medical ride share allowed. It is illegal to drive on your procedure day. Your ride must be at least 18 years old.
- Please bring your cell phone and wear your glasses, no contacts.
- Please leave all other valuables at home. The facility is not responsible for lost or missing items.
- If you are not able to understand, read or write English, please bring an interpreter.
- If you have a cough, cold, fever, or COVID call ahead to reschedule.

Please note that each procedure is unique and individualized based on the findings for each patient. Our goal is to always stay on time but please understand that at times unforeseen situations can affect our schedule. In this event, we may call you to instruct you to come at a different time.

Charles River Endoscopy Center * 571 Union Avenue Suite 201 (2nd Floor), Framingham MA 508-665-4111
is a freestanding ambulatory surgery center dedicated to Gastrointestinal Endoscopy. Patient satisfaction is our main goal. Our facility was chosen with quality, safety, patient privacy, and convenience in mind. Charles River Endoscopy Center is a member of the American Association of Ambulatory Surgery Centers (AAAHC). We do accept most insurance plans.

CHARLES RIVER ENDOSCOPY, LLC

YOUR DRIVER SHOULD REMAIN READILY AVAILABLE FOR TRANSPORT WHILE YOU ARE AT OUR CENTER. THEY ARE WELCOME TO REMAIN IN THE WAITING ROOM IF THEY PREFER.

Absolutely nothing to drink (clear liquids &/or prep) for 4 hours prior to the procedure as this will delay your procedure

Please discuss any medications that you take with your Prescribing Doctor and Gastroenterology doctor before discontinuing

Please fill out these three forms at home and bring with you on the day of your visit. You must also bring a form of identification & your insurance card(s) each time you visit our clinic. Thank you.

Last Name: ________ First Name: ________ Middle Initial: ____ Sex: M / F

Date of birth: ___/___/____ Age: ____ *Married Single Widowed* (circle) Height: ____ Weight: _____lbs.

Home Phone: (_____) __________ Cell Phone: (_____) __________

Please put an asterisk next to the preferred phone number to call you when doing a follow up call.

Address: __________ Town & Zip Code: __________

Email Address: __________ Ethnicity: __________ Language: __________

Do you need a translator (circle) Yes/ No Type: *Language / Speech / Hearing / Written Material* (circle)

Ride Home: __________ Phone: (___) ________ Phone: (___) ________

(Please provide a phone number even if your ride plans to stay. Your ride must be over 18 and present within a half hour of discharge/ no taxi car service can be used without a responsible adult to accompany you)

Have you been to Charles River Endoscopy before? Yes or No
If so please write date of last procedure: __________

AUTHORIZATION AND CONSENT FOR GENERAL TREATMENT AND BILLING

1. I wish to be treated at Charles River Endoscopy LLC. While in the center, I permit my doctor, Charles River Endoscopy LLC, and its employees and all other persons caring for me to treat me in the ways that they judge beneficial to me. I understand that this care may include tests, examinations, photography, the administration of medication and medical treatment.
2. I authorize Charles River Endoscopy LLC to furnish information and/or photocopies of my medical record for this treatment which record may or may not contain privileged information, to an insurer, compensation carrier, social security administration or welfare agency which may be providing financial assistance for my hospital care.
3. I hereby authorize payment directly to Charles River Endoscopy LLC of any group benefits, private policy benefits, and major medical benefits as determined by the insurance company or Medicare benefits. I also authorize payment directly to the physician or organization furnishing the services or authorize such physician or organization to submit a claim for treatment rendered, but not to exceed regular charges for the service.
I understand that I am responsible for the hospital and physician(s) charges not covered by this visit.
4. I permit a copy of this authorization to be used in place of the original.
5. I have received a copy of Charles River Endoscopy LLC's Notice of Privacy Practices/ HIPPA.
6. I authorize payment of Medigap Benefits to Charles River Endoscopy LLC for services provided.

X __________ __________ __________
Patient's Signature Date Time

If applicable: The patient is unable to sign due to __________

I therefore, consent for the patient (print name) __________

X __________
Signature of Patient Representative *Relationship* *Date* *Time*

Print name of Representative __________ ID __________

____
Witness *Date* *Time* *Print Name of Witness*

____
Witness *Date* *Time* *Print Name of Witness*

CHARLES RIVER
ENDOSCOPY, LLC

PLEASE CIRCLE THE SPECIFIC ITEM YOU ARE ANSWERING "YES" TO IN ORDER TO MAKE IT VERY CLEAR TO OUR HEALTH CARE PROVIDERS

Pre-Procedure Medical Form

Name: ______________________

Procedure: ______________________

Reason for Procedure: ______________________

____

Doctor: ______________________

Yes No
- ☐ ☐ Immune problems: Type: ____________
- ☐ ☐ Any type of cancer: Type: ____________
- ☐ ☐ Do you have any difficulty walking up a flight of stairs?

Cardiac Problems:

Yes No
- ☐ ☐ High Blood Pressure
- ☐ ☐ Valve Replacement; Date of surgery: ______
- ☐ ☐ Heart Murmur/Palpitations/ Arrhythmias
- ☐ ☐ Chest pain/Heart Attack; Date: ________
- ☐ ☐ Pacemaker; Date of placement: ________
  Last Date Tested: ________
- ☐ ☐ Pacemaker with a Defibrillator
- ☐ ☐ Bypass or angioplasty; Date of surgery: ____
- ☐ ☐ Swelling of Extremities
- ☐ ☐ Irregular heart rate/ Atrial Fibrillation (Afib)
- ☐ ☐ Have you ever had a stress test?
- ☐ ☐ Other: ______________

Respiratory Problems:

Yes No
- ☐ ☐ Asthma/ COPD/ Emphysema
- ☐ ☐ Sleep Apnea; Type of device: ________
- ☐ ☐ Do you snore?
- ☐ ☐ Tuberculosis
- ☐ ☐ Smoke (now/ past); Amount: ________
- ☐ ☐ Other: ______________

Liver/Gallbladder Problems:

Yes No
- ☐ ☐ Hepatitis: A B C
- ☐ ☐ Cirrhosis/Liver Disease
- ☐ ☐ Gallbladder Disease/Surgery
- ☐ ☐ Recreational Drug Use; Type: ________
- ☐ ☐ Alcohol Use; Amount: ____________
- ☐ ☐ Other: ______________

Neurological Problems

Yes No
- ☐ ☐ Stroke
- ☐ ☐ Seizure
- ☐ ☐ Headache
- ☐ ☐ Dizziness
- ☐ ☐ TIA
- ☐ ☐ Active shingles
- ☐ ☐ Glaucoma

Blood Disorders:

Yes No
- ☐ ☐ Anemia
- ☐ ☐ Clotting / Bleeding disorders
- ☐ ☐ Bruising
- ☐ ☐ Active MRSA infection
- ☐ ☐ HIV/ AIDS
- ☐ ☐ Other: ______________

Endocrine Problems:

Yes No
- ☐ ☐ Thyroid problems
- ☐ ☐ Diabetes Insulin__ Oral__ Diet controlled__

Orthopedic Problems:

Yes No
- ☐ ☐ Limitation of movement; Where: ________
- ☐ ☐ Joint Replacement ____________
- ☐ ☐ Metal pins, rods, plates: ________
- ☐ ☐ Body piercings ____________

Psychiatric:

Yes No
- ☐ ☐ Depression/ Anxiety/ Panic Disorders
- ☐ ☐ Confusion/ Developmental Delays
- ☐ ☐ Bipolar/ Schizophrenia
- ☐ ☐ Other: ______________

Kidney/Prostate Problems

Yes No
- ☐ ☐ Kidney Failure/ Kidney Stones
- ☐ ☐ Urinary Incontinence

Men Only:
- ☐ ☐ Prostate Enlargement
- ☐ ☐ Prostate Cancer
- ☐ ☐ Other: ______________

Women Only:

Yes No
- ☐ ☐ Hysterectomy
- ☐ ☐ Mastectomy/Lumpectomy R L
- ☐ ☐ Are you pregnant? Y___ N___ N/A ___
  Date of last menstrual period: ________

GI Problems:

Yes No
- ☐ ☐ Family History of Colon Cancer
  Relationship: ______________
- ☐ ☐ Personal History of Colon Cancer
- ☐ ☐ Family History of Colon Polyps
  Relationship: ______________
- ☐ ☐ Personal History of Colon Polyps
- ☐ ☐ Diverticulosis/Diverticulitis
- ☐ ☐ Colitis/Crohns
- ☐ ☐ Irritable Bowel Syndrome
- ☐ ☐ Bleeding/ Hemorrhoids
- ☐ ☐ Constipation/Diarrhea
- ☐ ☐ Stomach Ulcers
- ☐ ☐ Barrett's Disease
- ☐ ☐ Esophageal Strictures/Choking
- ☐ ☐ Acid Reflux
- ☐ ☐ Cdiff
- ☐ ☐ Trouble swallowing/ food sticking
- ☐ ☐ Weight Loss/Nausea/Vomiting

CHARLES RIVER
ENDOSCOPY, LLC

Pre-Procedure Medical Form

Name: ______________________ Height: ________ Weight: ________

Primary Care Physician:
Name first and last name: ______________________
Location: ______________________

Pharmacy Info:
Name: ______________________
Location: ______________________

Please list any other Medical/Surgical History/ hospitalizations or other problems/ concerns that you have:

____

____

____

Any relevant family history: ______________________

Yes No Have you or any family members ever have any problems with anesthesia in the past? Type: __________
Yes No May we leave a message on your home/cell answering machine regarding your care?
Yes No Can we discuss the procedure with anyone other than you (i.e. your ride, primary care, family etc.)

Do you use (circle that apply): eyeglasses contacts hearing aids dentures

Yes No Latex Allergy/ Egg/ Soy/ Nut? (please circle any that apply) & **Reaction:** ______________________

Medication Allergy (if present, please list the reaction)? ______________________

Other Allergy (if present, please list the reaction)? ______________________

Please List ALL Current Medications/Vitamins *(Prescriptions AND Over the Counter)*

	Medication	Dose	Frequency	Last Dose (*Important*)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Patient Signature: ______________________ Date: __________

Nurses Signature: ______________________ Date: __________

This information has been reviewed and updated with the patient prior to the procedure.

Copy of Bill of Rights, Informed Consent & Privacy Policy given to patient to review prior to procedure. ☐