



4100 Park Forest Drive, Suite 208, Traverse City, MI 49684
Telephone (231) 935-5710 Fax (231) 935-9045
www.dha-nm.com

NULYTELY COLONOSCOPY PREP INSTRUCTIONS (Split-Dose Prep)

Your Colonoscopy is scheduled for: _____

- € Your procedure is scheduled at the Northwest Michigan Surgery Center. You will receive an automated telephone message two days prior to your procedure with your appointment time and arrival information. If you do not receive this call, please call the office the day prior to your scheduled appointment to verify this information.
- € Your procedure is scheduled at Munson Medical Center. Please report to Munson Registration by: _____

COLONOSCOPY

This procedure is a direct examination of the colon through a flexible lighted scope, which is inserted through the rectum. For the examination, you will lie on your left side for the passage of the scope. A lubricating jelly will be placed in the rectum to decrease discomfort. An intravenous catheter will be placed in one of your arms to administer sedative medications. Please advise the nurse if you are allergic to any medications.

The examination should take approximately 30-45 minutes. You should plan to remain in the outpatient treatment area until the medication effects have worn off partially. After the examination there is generally a temporary feeling of fullness in the colon, and air can be expelled through the rectum.

We require that you bring a driver. You should not drive or operate power machinery the day of the colonoscopy, as the medications may affect your judgment.

Listed below are the things you need to do to evacuate your colon prior to the test. Be sure to read the instructions. Obtain a prescription for the prep solution from your doctor.

- STEP 1:** **DRINK ONLY CLEAR LIQUIDS THE DAY PRIOR TO YOUR EXAM.** (But, if your procedure is scheduled after 1:00 pm, you may have a light breakfast the day before the procedure, then begin a clear liquid diet.) You may continue the clear liquid diet until 4 hours prior to your scheduled test.
- STEP 2:** In the morning, the day **before** your exam, add lukewarm water to the top of the line on the NULYTELY bottle. Shake to dissolve the powder. Place the bottle in the refrigerator.
- STEP 3:** **At 6:00 pm** (the evening before the test) begin to drink ½ of the Nulytely solution. Drink 1 (8oz) glass every 10 minutes (about 8 glasses). Rapid drinking is preferred and you may drink with a straw. Then you may have all the clear liquids that you wish.

STEP 4: **5 hours prior to your scheduled arrival time,** begin to drink the other ½ of the Nulytely solution. Drink 1 (8oz) glass every 10 minutes (about 8 glasses) until all contents have been consumed. Then you do not consume anything until after your procedure.

*Mild nausea and abdominal fullness are expected with this preparation. If you experience severe nausea or vomiting, stop the preparation for 30 minutes to one hour, and then restart at the same rate as before. The bowel movements should eventually become clearer.

TIPS FOR COLON PREPARATION:

- Chilling the solution makes it taste better, but may make you feel cold. You may want to drink it at room temperature.
- Stay close to the bathroom.
- If you have a hard time drinking a full 8 oz every 10-15 minutes, try drinking 4 oz every 7-8 minutes.
- You may suck on a Brach's lemon drop (hard candy) to help rid the salty aftertaste.
- If your bottom gets sore from too much wiping, try putting Vaseline on the tender areas.

During the prep, it is very important to keep hydrated. Make sure you drink plenty of clear liquids.

CLEAR LIQUID DIET

This diet includes low residue fluids that are easily absorbed with minimal digestive activity. This diet does not contain all essential nutrients and is recommended if clear liquids are temporarily needed. **No RED or PURPLE liquids** should be consumed. You can have any of these foods at any time up **until 4 hours** before your test.

*****4 hours before your test, you will need to refrain from everything including water**

This a list of food/liquids allowed. Please **choose only** items from this list.

water
flavored water
decaffeinated tea
carbonated beverages, such as sprite,7up,gingerale (**avoid red, purple or dark sodas**)
fruit flavored drinks (**no red or purple colors**)
weak coffee
strained fruit juices (**no red or purple colors**)
apple juice
white grape juice
powdered lemonade
white cranberry juice
clear broth (chicken or beef)
bouillon cubes
Jello (**no red or purple colors**)
popsicles (**no red or purple colors**)
sugar
honey
syrup
clear hard candy (**no red or purple colors**)



Medications:

- You may take your pills with sips of water up to three hours before your test.

Aspirin, Coumadin and other Blood Thinners:

- If you take Coumadin (Warfarin), Ticlid, Plavix, Heparin, Aggrenox, Lovenox, Effient, or Persantine please ask the doctor who prescribed this medication for you when you should stop taking it.
- If you take Coumadin (Warfarin), or Plavix, you must see us in the office or speak with someone from our office at least seven days prior to your procedure.

Diabetics:

- Do not take your insulin if your test is before noon. Bring it with you.
- If your test is after noon, take one-half of your usual dose of long-acting insulin (NPH, Lente, Semi Lente). If you take 70 /30 insulin take 1 /3 of your normal dose.
- Do not take any regular or short-acting insulin.
- If you take pills for your diabetes, do not take them on the day of your test. Bring them with you.
- We would rather your sugar was running a little high than low.

If you have any questions or concerns regarding the preparation, please call and discuss them with our nurse. Office hours are Monday-Friday, 8:00a.m. to 5:00p.m. If you experience extreme pain or vomiting, please call the office immediately. Contact the Gastroenterologist at Munson Medical Center (231) 935-5000 if you experience these difficulties after hours.

Digestive Health Associates of Northern Michigan, P.C.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. *Digestive Health Associates of Northern Michigan, P.C. (DHA)* is permitted to make uses and disclosures of protected health information for treatment, payment and health care operations, as described in the following examples:
 - a. For treatment – such as progress updates to your primary care physician.
 - b. For payment – such as claims for services rendered being sent to your insurance carrier.
 - c. For health care operations – for example, we may call you by name in the waiting room when your provider is ready to see you.
2. *DHA* is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization.
3. Other uses and disclosures will be made only with the Individual's written authorization, and the individual may revoke such authorization.
4. *DHA* intends to engage in (n)one or more of the following activities:
 - a. *DHA* may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.
 - b. A group health plan, or a health insurance issuer or HMO with respect to a group health plan, may disclose protected health information to the sponsor of the plan.
5. The Individual has the following rights regarding protected health information:
 - a. The right to request restrictions on certain uses and disclosures of protected health information. *DHA* is not required to agree to a requested restriction, however.
 - b. The right to receive confidential communications of protected health information, as applicable.
 - c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.
 - d. The right to amend protected health information, as provided in the Privacy Regulation.
 - e. The right to receive an accounting of disclosures of protected health information.

- f. The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.
6. *DHA* is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and Privacy practices with respect to protected health information.
7. *DHA* is required to abide by the terms of the Notice currently in effect.
8. *DHA* reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains.
9. *DHA* will provide individuals or patients with a revised Notice by mail or in person at the time of the next scheduled visit.
10. Individuals may complain to *DHA* and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated. You may file a complaint with us by notifying our Practice Administrator. We will not retaliate against you for filing a complaint.
11. *DHA's* contact person for matters relating to complaints is:
 - a. *Practice Administrator*
 - b. *(231) 935-5710*
 - c. *4100 Park Forest Dr., Suite 208, Traverse City, MI 49684*
12. This Notice is first in effect on April 14, 2003.

Digestive Health Associates of Northern Michigan, P.C.

Acknowledgement of Receipt
Notice of Privacy Practices

I hereby acknowledge that I have received a copy of DHA's Notice of Privacy Practices.

Individual's Name

Date: _____



NOTICE

Your procedure is scheduled to take place at Northwest Michigan Surgery Center, LLC on (insert date)_____.

Northwest Michigan Surgery Center, LLC is a joint venture between a group of Traverse City physicians and Munson Medical Center to improve patient access to outpatient procedures in our community. The group of physicians owns the land and building which is leased to the joint venture – Northwest Michigan Surgery Center.

For the purpose of complete financial disclosure, we would like to inform you that Dr.'s **Rex Antinozzi, Robert Barnes, Mark Galan, Monty Hegewald, and Kurt Sanford** have ownership interests in the surgery center. As such, the fee for use of the facility will go to the joint venture.

All physicians on staff at Northwest Michigan Surgery Center are also on staff at other facilities in the area. You have the right to request that the procedure be performed at another facility. If you have questions regarding this issue, feel free to discuss it with your physicians.

By signing below, I acknowledge that I have read and understand this disclosure and wish to proceed with my scheduled surgery at Northwest Michigan Surgery Center.

Patient Signature

Date

Print Name



P A T I E N T I N F O R M A T I O N F O R M

										DATE	
PATIENT NAME - FIRST			MIDDLE			LAST	SE X				MARITAL STATUS
							M			F	S - M - W - D
PERMANENT ADDRESS				CITY		STATE		ZIP			
HOME PHONE			WORK PHONE			BIRTHDATE			AGE		
SOCIAL SECURITY #			DRIVER LICENSE #			EMPLOYER					
GUARDIAN (Relationship)					GUARDIAN SOCIAL SECURITY #			GUARDIAN EMPLOYER			
SPOUSE					SPOUSE SOCIAL SECURITY #			SPOUSE BIRTHDATE			
EMERGENCY CONTACT					PHONE NUMBER						
REFERRING PHYSICIAN OR FAMILY DOCTOR											

AUTHORIZATION TO RELEASE INFORMATION

I, _____ authorize Digestive Health Associates of Northern Michigan, P.C. (Drs. Antinozzi, Barnes, Galan, Goldman, Hegewald, Sanford, Sue Coffin, P.A.-C and Krystal Auernhamer, P.A.-C) to release and/or discuss information relevant to my care to the following individuals:

Spouse (Name) _____

Other (Name and relationship) _____

I also authorize information about my health care, including appointments, test results or other messages, to be left on my answering machine, in the event that I am not available.

YES _____ NO _____

I request payment of authorized Medicare or other insurance benefits be made to either myself or on my behalf to Digestive Health Associates of Northern Michigan for any services rendered to me. I authorize release of medical information about me to the Health Care Financing Administration (Medicare) and/or my insurance carrier. This information is to be used for the purpose of evaluating and administering benefits.

Medicare _____

Other Insurance (name of company) _____

I understand that I am financially responsible for any amount not covered by my insurance contract. I accept _____

responsibility for obtaining necessary referral forms.

This release will be considered valid from the date indicated below and will remain in effect until such time as I withdraw it in writing.

Signature _____ Date _____