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Medicine Professional Corporation

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GASTROSCOPY APPOINTMENT:

Date and time:

Registration:

Please go **FIRST** to Admitting Dept (Main Floor) to Register, then to Endoscopy Toronto East General Hospital, 825 Coxwell Ave, Toronto
(*the closest entrance is the main one, off Coxwell Ave.*)

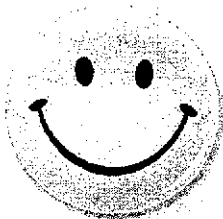
You must call my office at least 7 days ahead of time to confirm you will come for the test.
If we don't hear from you, we will cancel your test, and leave a message at your telephone number.

PREPARATION:

On Day of Test:

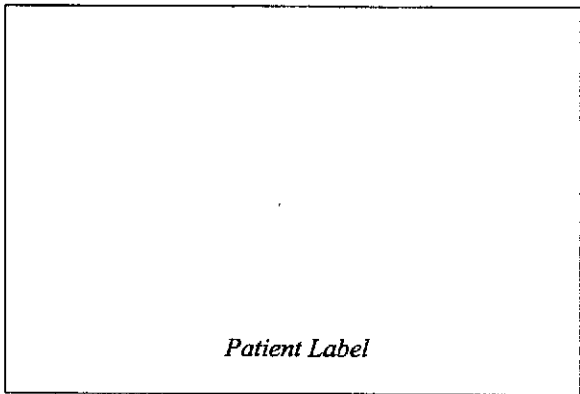
- No solid food after midnight.
- You can have water or apple juice until 3 hours before the test - - but **no milk**.
- Take all your usual medications (but no diabetic meds).
- Bring this note with you and your valid OHIP card.
- Please leave a message at the office 416-463-6053 if you are delayed or have to cancel (messages can be left 24 hours).
- Bring a book to read if you wish as your test may be delayed if there are emergency cases.

AFTER THE TEST:



- You cannot drive home after the test (because of the sedation used) and cannot drive until the following morning. Please have someone pick you up (the hospital mandates that sedated patient must have an escort home)
- You can start eating 1 hour after the test, but avoid fatty food until the next morning (*this reduces bloating*).
- **After the test, I will give you a brief report. The full dictated report takes 4-5 weeks to get typed by the hospital and to get to your doctor.**
- After the test, in the rare event that you have severe pain, fever, or bleeding – please go to the nearest emergency room immediately and show them the report (the office cannot do the needed emergency tests). Call the office from the E.R. Please do not hesitate to ask me or your family doctor if you have any questions about the test.

**CONSENT FOR OPERATION, DIAGNOSTIC
TEST, MEDICAL TREATMENT and
BLOOD TRANSFUSION**



This form tells you about your rights.

Please read the form.

Ask about any part you do not understand.

Be sure you have your questions answered before you sign this form.

When you sign it, you are giving us permission to do this surgery or procedure or treatment.

For Blood Transfusion you are signing to accept/refuse the transfusion or that you do not need a blood transfusion after checking one of the options in the box.

I _____ give permission for
(Name of patient)

Doctor Gopinath to perform
(Name of Doctor)

Colonoscopy +/- biopsy / polypectomy

Risks: bleeding → transfusion
perforation → operation
sedation
missed cancer

(Name of Operation and/or Procedure and/or Treatment, e.g. Blood products)

I understand that my doctor may need to do extra tests or procedures during the operation that are needed right away. I know that Michael Garron Hospital is a teaching hospital. This means that other doctors, residents and medical students may help in my care under the supervision of my doctor.

My doctor or health practitioner has explained my surgery or procedure to me and

- I understand the reason for my surgery or procedure or treatment and/or blood transfusion
- I understand the benefits of my surgery or procedure or treatment and/or blood transfusion
- I understand the possible risks of my surgery or procedure or treatment and/or blood transfusion
- I understand there is no guarantee of the results
- I understand the doctor may remove tissue or body parts during this surgery or procedure. If it is not used for lab studies or teaching, it will be disposed of, as the law requires.

- I consent to receive blood transfusion and/or blood product.
 - I **DO NOT** consent to receive a blood transfusion and/or blood products.
 - I have received the Blood Transfusion Brochure.
 - Not Applicable means it is not anticipated that I will need blood at this time.

Date

Signature of Patient/Substitute Decision Maker

Relationship of Substitute Decision Maker to Patient

Please print name

If the patient does not read or understand English this consent **must** be interpreted for the patient.

Signature of Interpreter/ID Number

Please Print your Relationship to Patient

ANAESTHESIA PRE-ENDO QUESTIONNAIRE



SP-782

Patient Label

Weight:	kg/lbs	Height:	cm/ft
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Who is escorting the patient home? Name: _____ **Cell Phone No:** _____

Please list any medications you currently take (prescribed, over-the-counter, herbal):

<input type="checkbox"/> none

Please list any allergies to medications or food:

<input type="checkbox"/> none

Do you or have you ever had any of the following conditions:

No	Yes	Don't Know	Details
Any possibility of pregnancy			
High blood pressure			
Heart attack / angina			
Atrial fibrillation / palpitations			
Stroke or mini-stroke (TIA), Seizure Disorder			
Diabetes			
Smoking			
Shortness of breath			
Asthma			
Chronic Obstructive Pulmonary Disease (COPD)			
Recent cough / cold / wheezing			
Sleep apnea			
Hiatus hernia / reflux (GERD) / heartburn			
Liver problems or hepatitis			
Kidney problems			
Bleeding tendencies			
Street drug use			
Drink any alcohol (please specify # of drinks/week)			
Communicable disease (eg. HIV, hepatitis, herpes)			
Artificial body parts (joints, plates, implants, contact lenses)			
Previous reaction to general anesthetics			
Family history of problems with anesthetics			

Please list any previous surgeries or ongoing medical problems not listed above:

<input type="checkbox"/> none

Please do not eat or drink any solid food on the day of the procedure. You may have water, clear tea, black coffee, (NO milk or cream), or clear apple juice until 2 hours prior to your scheduled procedure. Do not suck on any hard candy or chew gum at least 2 hour prior to the procedure.

Please take your usual medications with sips of water on the day of surgery with the exception of diabetic medications, and blood thinners. If you take insulin please ask your doctor if you should take any insulin on the day of the procedure.