GI Excellence, Inc.

Gastroenterology Associates

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Two Locations:

HEMET
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TEMECULA
44274 George Cushman Ct. · Suite 208 · Temecula, CA 92592 · (951) 383-6001
(By appt.)

PATIENT DISCHARGE INSTRUCTIONS

Procedure: ______________________________ Date of Service: ______________

Patient Name: ______________________________ DOB (age): ______________

Endoscopist(s): ____

IMAGES:

Dear Patient,

We performed a colonoscopy today based on the following indications:

During the procedure, we found the following:

Our recommendations are as follows:

It is very important that you follow these instructions:

ACTIVITY:

DO NOT drive a car or operate machinery until the following day. You agree NOT to hold your physician and/or Hemet Endoscopy Center / GI Excellence, Inc. responsible for any complications or accidents in the event you fail to follow these instructions.

Following day: Return to full activity including work.

For three (3) days: NO heavy lifting, straining or running.

DIET:

Eat and drink normally unless otherwise instructed.

If marked:

- Avoid all seeds and nuts
- Take Metamucil - one tablespoon with 2 glasses of water
- High fiber diet

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TREATMENT FOR COMMON AFTER EFFECTS:

Mild abdominal pain, bloating or excessive gas; rest, eat lightly and use a heating pad.

SYMPTOMS TO WATCH FOR AND IMMEDIATELY REPORT TO YOUR PHYSICIAN:

1. SEVERE abdominal pain or bloating
2. Fever within 24 hours after the procedure
3. A large amount of rectal bleeding. (A small amount from the rectum is not serious, especially if hemorrhoids are present)

IF A POLYP HAS BEEN REMOVED:

For the next seven (7) days do not take aspirin

For the next seven (7) days do not take long car trips

If bright red bleeding occurs, call your physician

If you have any questions or problems, please call your physician.

Instructions given by: ______________________________

X:______________________________

**signature of patient, guardian or other, signifying understanding of instructions and a receipt of a copy of these instructions

Relationship to patient:

Follow-up appointment:

Even though this appointment is a follow-up to you procedure, some HMOs require a new referral for this appointment.

Please check with our offi ce at least one (1) week prior to your scheduled appointment if you have any questions. **Normal offi ce co-pays apply to your follow-up visit.** If you are unable to pay your co-pay, your appointment will need to be rescheduled.

The above named patient has been informed that he/she must have a drive following the procedure. We have been informed that you are the person whom the patient has designated as his/her driver. You accept full responsibility for immediately driving this patient home following the procedure. (The patient has had sedation that will affect his/her driving ability).

**Driver's signature:______________________________ Date:______________________________

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Physician Test, MD