

**PATIENT NAME:** \_\_\_\_\_

**PROCEDURE DATE:** \_\_\_\_\_ at \_\_\_\_\_ with \_\_\_\_\_

Please arrive to the Toronto Immune and Digestive Health Institute at: \_\_\_\_\_  
700 Lawrence Ave. W., 3<sup>rd</sup> floor, Suite 360, Toronto, ON, M6A 3B4 (T: 647-812-2113)  
Enter through the East Tower Entrance, located between Booster Juice and the Foot Institute

Arrange for a pick-up **2 hours after your procedure start time.**

If you do not have an adult accompany you home, your procedure will be cancelled.

The Colonoscopy Package includes the following documents:\*

1. Colonoscopy Preparation Instructions (2 pages)
2. Pre-Anesthesia Questionnaire (3 pages)
3. Colonoscopy & Polypectomy Information (2 pages)

\*Contact the office immediately if you are missing any of the documents listed above.

Please read **ALL** the documents enclosed within the Colonoscopy Package carefully. Failure to follow the instructions may result in the cancellation of your procedure.

If you have any questions or require further information, please contact the clinic and one of our staff members will be happy to assist you.

Toronto Immune and Digestive Health Institute  
700 Lawrence Avenue West  
3<sup>rd</sup> floor, Suite 360,  
Toronto, ON M6A 3B4  
Phone: 647-812-2113  
Email: reception@tidhi.ca

**CANCELLATION POLICY**

You will be called by our office two weeks prior to your scheduled procedure to remind you of your appointment date and time. If our office is not able to speak with you directly, you **must** call the clinic at 647-812-2113 no later than 5 business days prior to your scheduled procedure. Failure to confirm your appointment in a timely manner may result in your procedure time being given away to another patient.

**CANCELLATIONS WITH LESS THAN 5 BUSINESS DAY'S NOTICE WILL RESULT IN A \$200 FEE NOT COVERED BY OHIP**

**PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY**

**MEDICATIONS TO DISCONTINUE:**

- **Iron medications** – stop at least **10** days prior to the procedure
- **Aspirin** – stop at least **7** days prior to your procedure, after consulting with your physician
- **Coumadin (Warfarin) or Xarelto (Rivaroxaban)** – you may need to temporarily discontinue these medications. Please discuss this with your prescribing physician well in advance of the procedure
- **Insulin or pills for Diabetes** – please discuss with your family physician prior to the test
- If you have an abnormal heart valve, prosthetics heart valve or other conditions where you have been told to take antibiotics prior to dental procedures, please advise us immediately.

**1. TWO WEEKS PRIOR to your procedure:**

- Call the clinic at 647-812-2113 to confirm your procedure
- Complete the Pre-Anesthesia Questionnaire and submit to the clinic via email ([reception@tidhi.ca](mailto:reception@tidhi.ca)) or fax (**647-812-2114**)
- Purchase the following bowel prep materials over-the-counter at your local pharmacy:
  - (1) box of Bi-Peglyte (contains two Peglyte sachets and three Bisacodyl tablets)

**2. ONE WEEK PRIOR to your procedure:**

- STOP eating whole grains, nuts, seeds, dried fruit, or raw fruits/vegetables

**3. ONE DAY PRIOR to your procedure:**

- **BEFORE 9:00 am: EAT A LIGHT BREAKFAST**
- **At 9:00am:** Dissolve the entire contents of one sachet in 1 litre of water and mix rapidly until a clear solution forms. Repeat with the second sachet. Refrigerate until you are ready to take it.
- **Beginning after 9 AM:** drink ONLY clear fluids (the entire day prior to procedure)
  - DO NOT DRINK OR EAT any solid or milk dairy products
  - DO NOT DRINK any fluids with red or purple colour.
  - **Clear fluids include:** soft drinks (sprite, 7-UP, Ginger Ale), clear broth, fruit juices (without pulp), water, tea or coffee (without milk or cream), jell-o, ice popsicles
- **At 3:00pm:** take all three Bisacodyl tablets that came in the kit with water
- **At 7:00pm**
  - Drink 250ml of the Peglyte solution every 10-15 minutes over one hour until the solution is finished
  - Drink an additional 1 litre (as tolerated) of clear fluids after finishing the first sachet
  - Expect to have multiple bowel movements. Although some people do not have them immediately and it can take a few hours.

**4. DAY OF PROCEDURE:**

- **FIVE HOURS BEFORE YOUR PROCEDURE DRINK THE SECOND LITRE (if your procedure is at or before 9:00 AM, start at 5:00 AM)**
  - Drink 250ml of the Peglyte solution every 10-15 minutes over one hour until the solution is finished
  - Drink an additional 1 litre (as tolerated) of clear fluids after finishing the first sachet
  - The bowel is clean when you are passing yellow liquid with no particles. If this is not the case, drink more fluids.
- Take all of your usual medications (except those listed on page 1) with small sips of water.
- **DO NOT DRINK ANYTHING 4 HOURS PRIOR TO YOUR PROCEDURE**
- **DO NOT EAT ANYTHING THE DAY OF THE PROCEDURE**

**IMPORTANT INFORMATION**

- If you have sleep apnea plan to bring your CPAP machine to the procedure
- Continue any blood pressure medication as usual
- If you missed any of the steps on the previous page, PLEASE STILL COME IN FOR THE PROCEDURE
- DO NOT BRING ANY VALUABLES JEWELLERY OR WEAR MAKE UP
- You will be sedated during the procedure. Therefore, **YOU MUST BE ACCOMPANIED BY SOMEONE WHEN YOU LEAVE.** If you do have someone to accompany you, your procedure will be cancelled.

**WHEN YOU ARRIVE**

- The Toronto Immune and Digestive Health Institute is located in the Lawrence-Allen Centre at (700 Lawrence Avenue West). There is free, unlimited parking and adjacent TTC/Subway access (Lawrence West Station).
- Please enter through the East Tower entrance, which is accessible from the parking lot on the south side of the mall facing Lawrence Avenue. The East Tower entrance can be found between Booster Juice and the Foot Institute.
- Once inside, take the elevators up to the 3<sup>rd</sup> floor – Suite 360.
- Unfortunately due to COVID restrictions, your escort cannot accompany you inside the clinic. Your escort can visit the retail shops at the Lawrence-Allen Centre, which provides immediate access to food, shopping and other amenities. Your escort will be informed when you are ready to be picked up.

Please complete this form and email (reception@tidhi.ca) or fax (647-812-2114) a copy of the completed form to the clinic at least 14 days prior to your scheduled procedure.

Date of Procedure (MM/DD/YY):

|                           |               |                 |         |
|---------------------------|---------------|-----------------|---------|
| Name (Last, First, M.I.): |               | DOB (MM/DD/YY): |         |
| OHIP #:                   | Version Code: | Weight:         | Height: |
| Emergency Contact Name:   | Relationship: | Phone:          |         |

### MEDICAL HISTORY

| Cardiac Health          |                              |                             |
|-------------------------|------------------------------|-----------------------------|
| Angina                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hypertension            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Myocardial Infarction   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Atrial Fibrillation     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart murmur            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cardiac Valve Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pacemaker               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stent/Angioplasty       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other:                  |                              |                             |

| Blood Health       |                              |                             |
|--------------------|------------------------------|-----------------------------|
| Anemia             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sickle Cell Trait  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sickle Cell Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding Disorder  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| DVT or PE          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Aneurysm           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| HIV/AIDS           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other:             |                              |                             |

| Respiratory Health                        |                              |                             |
|-------------------------------------------|------------------------------|-----------------------------|
| Asthma                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| COPD                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tuberculosis                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sleep Apnea <input type="checkbox"/> CPAP | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other:                                    |                              |                             |

| Endocrine and Metabolic Health                                            |                              |                             |
|---------------------------------------------------------------------------|------------------------------|-----------------------------|
| Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Thyroid Disease name:                                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other:                                                                    |                              |                             |

| Gastrointestinal Health         |                              |                             |
|---------------------------------|------------------------------|-----------------------------|
| Heartburn or GERD               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hiatus Hernia                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Liver Disease name:             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Inflammatory Bowel Disease      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Difficulty Eating or Swallowing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nausea or Vomiting              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other:                          |                              |                             |

| Neuro and Musculoskeletal Health |                              |                             |
|----------------------------------|------------------------------|-----------------------------|
| Dementia                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Alzheimer's disease              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Migraine                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Vertigo                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Neuropathy                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fibromyalgia                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Spinal Stenosis                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Osteoarthritis                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rheumatoid Arthritis             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Epilepsy or Seizure Disorder     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Multiple Sclerosis               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Parkinson's disease              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other:                           |                              |                             |

| Kidney and Bladder Health    |                              |                             |
|------------------------------|------------------------------|-----------------------------|
| Kidney Disease <i>name:</i>  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, are you on dialysis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other:                       |                              |                             |

| Other Significant Conditions:            |
|------------------------------------------|
| <br><br><br><br><br><br><br><br><br><br> |

#### CURRENT MEDICATIONS

|                                                      |                                                                                               |
|------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> No prescription medications | <input type="checkbox"/> No over-the-counter medications, supplements, vitamins or probiotics |
|------------------------------------------------------|-----------------------------------------------------------------------------------------------|

| Medications, supplements, vitamins or probiotics: | Dose: | Frequency: | Indication: |
|---------------------------------------------------|-------|------------|-------------|
|                                                   |       |            |             |
|                                                   |       |            |             |
|                                                   |       |            |             |
|                                                   |       |            |             |
|                                                   |       |            |             |
|                                                   |       |            |             |
|                                                   |       |            |             |

#### ALLERGIES

| Medication or Substance <i>(e.g. latex, food, etc.):</i> | Type of Reaction: |
|----------------------------------------------------------|-------------------|
|                                                          |                   |
|                                                          |                   |
|                                                          |                   |

ANESTHETIC HISTORY

|                                                                                   |                                               |                                                                  |
|-----------------------------------------------------------------------------------|-----------------------------------------------|------------------------------------------------------------------|
| Have you ever had general anesthesia?                                             | <input type="checkbox"/> Yes                  | <input type="checkbox"/> No                                      |
| <i>If yes, please describe:</i>                                                   |                                               |                                                                  |
| Have you ever had regional anesthesia? (e.g. nerve block, epidural, spinal, etc.) | <input type="checkbox"/> Yes                  | <input type="checkbox"/> No                                      |
| <i>If yes, please describe:</i>                                                   |                                               |                                                                  |
| Have you had any reactions to anesthesia in the past?                             | <input type="checkbox"/> Yes                  | <input type="checkbox"/> No <i>If yes, check/describe below.</i> |
| <input type="checkbox"/> Malignant Hyperthermia                                   | <input type="checkbox"/> Pseudocholinesterase | <input type="checkbox"/> Confusion after surgery                 |
| <input type="checkbox"/> Other Reaction:                                          |                                               |                                                                  |
| Has a family member ever had a serious reaction to anesthesia?                    | <input type="checkbox"/> Yes                  | <input type="checkbox"/> No                                      |
| <i>If yes, please describe:</i>                                                   |                                               |                                                                  |

ADDITIONAL SCREENING QUESTIONS

|                                                       |                              |                                                                   |
|-------------------------------------------------------|------------------------------|-------------------------------------------------------------------|
| Do you bruise easily?                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No                                       |
| Do you use home oxygen?                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No                                       |
| Do you have loose teeth or dentures?                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No                                       |
| Do you have any severe visual or hearing impairments? | <input type="checkbox"/> Yes | <input type="checkbox"/> No                                       |
| Do you drink alcohol?                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No <i>If yes, number of drinks/week:</i> |
| Do you smoke?                                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No <i>If yes, type + amount/week:</i>    |
| Do you use recreational drugs?                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No <i>If yes, type + amount/week:</i>    |
| If female, are you currently pregnant?                | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> N/A          |

Patient Signature

Date (MM/DD/YY):

## **BEFORE YOUR PROCEDURE**

### **What is a Colonoscopy?**

A colonoscopy is an examination of the large intestine and part of the small intestine with a camera on the end of a tube. Instruments may be passed through the colonoscope to take tiny, painless biopsies (samples of tissue) for microscopic examination in the laboratory. Photographs and video may also be taken during the procedure. Colonoscopy is used to in inflammatory bowel disease (IBD/Crohn's disease, ulcerative colitis) to assess the extent and severity of the inflammation and/or to evaluate treatment response. It is also used to detect and diagnose colon cancer, polyps, causes of bleeding and diarrhea. There is very little risk associated with colonoscopy and polyp removal/biopsies when they are performed by specially trained physicians and health care teams.

### **What is a Polypectomy?**

During the course of your colonoscopy, a polyp may be found. Polyps are abnormal growths of tissue which vary in size from a few millimeters to several centimeters. Depending on the size, shape and location of the polyp, it may be removed (polypectomy). You should feel no pain during polyp removal. Polyps are usually removed because they can be a source of rectal bleeding or may contain cancer. Although the majority of polyps are benign (not cancerous), some may eventually become cancerous if left untouched.

### **What to Expect**

- You will be admitted to the endoscopy suite
- A blood test may be taken
- You will change into a patient gown
- You will empty your bladder
- Your vital signs will be taken
- You will be given an intravenous injection to make you sleepy and relaxed
- The examination will be done with you lying on your left side
- The colonoscope will be introduced via your rectum or stoma so your bowel can be examined
- You may feel some cramping and pressure

## **AFTER YOUR PROCEDURE**

### **After the Colonoscopy**

You will be taken to the Endoscopy recover area where you will remain until most of the effects of the medication have worn off. When your nurse and anesthetist has decided that you are sufficiently recovered, your escort will be called to pick you up. You will be discharged to your escort. You will not be allowed to drive for 24 hours.

### **Complications**

Complications are extremely rare but can occur. One complication is perforation or tear through the wall of the bowel that may allow leakage of intestinal fluids. This complication may require surgery or management with antibiotics and intravenous fluids. Bleeding may occur from a biopsy or polyp removal. This is usually minimal but, rarely, blood transfusions or surgery may be required. Irritation of a vein can occur at an intravenous site. A tender lump or bruise may develop and last from several days to months. It eventually goes away with no ill effects. Other risks include drug reactions and complications from unrelated medical conditions. Your physician and his staff are alert to the possibilities and are fully equipped to handle any complications which may arise.

### **Results**

The results will be explained at the conclusion of your procedure. Because of the sedation, you may not remember what you have been told. If you require further explanation, you should call the physician who performed the procedure or make an office appointment for a complete explanation. If biopsies have been taken, results can take 10 -14 days to be available. Please call the office to follow up.