

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) or fax (**647-812-2114**)
- Purchase the following bowel prep materials over-the-counter at your local pharmacy:
 - (1) box of **Pico-Salax** (contains two sachets)
 - (1) box of **Dulcolax 5mg** 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:

- You must be on **clear fluids ALL DAY**
 - **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 5:00pm:** Take **two Dulcolax tablets** with water
- **At 8:00pm:** Take **first dose of Pico-Salax**
 - Empty the contents of 1 sachet of Pico-Salax into a cup. Add 150 mL of cold water and stir frequently for 2 -3 minutes. Sometimes the reaction of mixing PICO-SALAX and cold water will cause the solution to become hot. It becomes hot, wait until it cools sufficiently to drink.
 - Drink an additional 1 litre (as tolerated) of clear fluids after finishing the first sachet

4. DAY OF PROCEDURE:

- **At 6:00am:** Take **second dose** of **Pico-Salax** (same instructions as first dose)
 - Drink plenty of clear fluids (as tolerated) of clear fluids after finishing the second sachet
- Take all of your usual medications (except those listed on page 1) with small sips of water.
- **NOTHING TO EAT OR DRINK 4 HOURS PRIOR TO YOUR 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 3rd 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.

PRE-ANESTHESIA QUESTIONNAIRE

Please submit completed questionnaire by fax (647-812-2114) or email (reception@tidhi.ca) at least 14 days prior to the 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:

CURRENT MEDICATIONS

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