TORONTO IMMUNE & DIGESTIVE HEALTH INSTITUTE

SIGMOIDOSCOPY PREPARATION INSTRUCTIONS

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 popscicles
   - **At 2:00pm:** Take **two Dulcolax tablets** with water
   - **At 4:00pm:** 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 is becomes hot, wait until it cools sufficiently to drink.
     - Drink an additional 1 litre (as tolerated) of clear fluids after finishing the first sachet
   - **At 8:00pm:** Take **second dose** of **Pico-Salax** (same instructions as first dose)
     - Drink an additional 1 litre (as tolerated) of clear fluids after finishing the second sachet

4. **DAY OF PROCEDURE:**
    - **At 12:00am: BEGIN FASTING – NOTHING TO EAT OR DRINK THE DAY OF THE PROCEDURE**
    - Take all of your usual medications (except those listed on page 1) with small sips of water.

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.

TORONTO IMMUNE & DIGESTIVE HEALTH INSTITUTE

700 LAWRENCE AVE W, SUITE 360
TORONTO, ONTARIO M6A 3B4

T: 647 812 2113
F: 647 812 2114

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	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Myocardial Infarction	☐ Yes	☐ No
Atrial Fibrillation	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No
Cardiac Valve Disorders	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Stent/Angioplasty	☐ Yes	☐ No
Other:		

Blood Health		
Anemia	☐ Yes	☐ No
Sickle Cell Trait	☐ Yes	☐ No
Sickle Cell Anemia	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No
DVT or PE	☐ Yes	☐ No
Aneurysm	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Other:		

Respiratory Health		
Asthma	☐ Yes	☐ No
COPD	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Sleep Apnea ☐ CPAP	☐ Yes	☐ No
Other:		

Endocrine and Metabolic Health		
Diabetes ☐ Type I ☐ Type II	☐ Yes	☐ No
Thyroid Disease *name:*	☐ Yes	☐ No
Other:		

Gastrointestinal Health		
Heartburn or GERD	☐ Yes	☐ No
Hiatus Hernia	☐ Yes	☐ No
Liver Disease *name:*	☐ Yes	☐ No
Inflammatory Bowel Disease	☐ Yes	☐ No
Difficulty Eating or Swallowing	☐ Yes	☐ No
Nausea or Vomiting	☐ Yes	☐ No
Other:		

Neuro and Musculoskeletal Health		
Dementia	☐ Yes	☐ No
Alzheimer's disease	☐ Yes	☐ No
Migraine	☐ Yes	☐ No
Vertigo	☐ Yes	☐ No
Neuropathy	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No
Spinal Stenosis	☐ Yes	☐ No
Osteoarthritis	☐ Yes	☐ No
Rheumatoid Arthritis	☐ Yes	☐ No
Epilepsy or Seizure Disorder	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No
Parkinson's disease	☐ Yes	☐ No
Other:		

Kidney and Bladder Health		
Kidney Disease *name:*	☐ Yes	☐ No
If yes, are you on dialysis?	☐ Yes	☐ No
Other:		

Other Significant Conditions:

CURRENT MEDICATIONS

☐ No prescription medications	☐ No over-the-counter medications, supplements, vitamins or probiotics

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

ALLERGIES

Medication or Substance *(e.g. latex, food, etc.)*:	Type of Reaction:

ANESTHETIC HISTORY

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

ADDITIONAL SCREENING QUESTIONS

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

Patient Signature **Date** *(MM/DD/YY):*