



GATEWAY GASTROENTEROLOGY

St. Luke's Outpatient Center
121 St. Luke's Center Drive, Suite 406
Chesterfield, MO 63017
Office: (314) 432-5900
www.gatewaygi.com

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ENDOSCOPY PREPARATION INSTRUCTIONS

Please read this information as soon as you receive it!!

**If you have any questions about these instructions or to make a change to your appointment, Please call:
(314) 432-5900 (Office) Press Option 2
(314) 388-6519 (Exchange)**

Your procedure is scheduled for _____ at _____

Please arrive **1 hour prior** to your procedure. We work very hard to stay on schedule. We need this time to complete paperwork, place an IV, etc.

The St. Luke's GI/Endoscopy lab is located at 232 S. Woods Mill Road, Chesterfield, MO 63017. The GI/Endoscopy Lab is located on the first floor, Suite 130 of the East Medical Building.

From Hwy40/Interstate 64:

- ▶ Go north on Woods Mills Road (Hwy. 141) · mile to Conway Road.
- ▶ Turn right at the stoplight onto Conway Road. Turn left into the hospital east entrance.
- ▶ Turn left again into the east surface parking lot or East Garage (3 levels). There is direct access to the East Medical Building from Level 1 or 3. Complimentary valet parking is available and is highly encouraged. Valet parking begins at 7:30am.

If you cannot keep your scheduled appointment, please notify us at least **2 business days** before your scheduled time.

Please review the “special circumstances” section of this document carefully to see if you require special instructions or modifications.

PREPARATION:

- ▶ **Nothing to eat or drink after midnight.**
- ▶ **IF** your procedure is scheduled for **at or after 2:30 pm**, you may **consume clear liquids only before 7 am** the morning of your procedure.
- ▶ You may take your usual medications with sips of water **as early as possible on the day of the procedure.**

The day of the procedure:

- ▶ Arrive at the GI/Endoscopy Lab at St. Luke's Hospital **1 hour prior** to your scheduled procedure time. Visit St. Luke's Hospital website at www.stlukes-stl.com for maps and directions.
- ▶ **You will need someone to drive you to and from the hospital AND wait in the waiting room until the procedure is done. The procedure can't be done unless you have a driver. You will be there for approximately 2 to 2-1/2 hours from the time you arrive.**
- ▶ We have enclosed a patient information form and a medication list. **Please fill these out at home and bring them with you to your appointment along with your insurance cards and drivers license.** If you have any questions, the nurse will go over it with you at the time of your appointment.
- ▶ All Female Patients: If you are between the ages of 12-49, you will be required to give a urine specimen unless you have had a hysterectomy or Tubal Ligation.

SPECIAL INSTRUCTIONS:

Patients with an automatic implantable defibrillator and /or pacemaker: Please call us at least five (5) days before the procedure for instructions.

Coumadin (warfarin): Call your primary care doctor or cardiologist and ask if you can safely stop the Coumadin four (4) days before the procedure. If your doctor tells you that you cannot stop the Coumadin, then please call us immediately to make us aware of this. We will then discuss with you the various options available.

Antibiotics for procedures: Recent publications from both the American Heart Association and American Society for Gastrointestinal Endoscopy state that antibiotics are not necessary for routine endoscopic procedures.

Insulin: Call your primary care doctor at least five (5) days before the procedure and ask for instructions.

Plavix: (clopidogrel) and aspirin: It is not necessary to stop Plavix and aspirin prior to your procedure.

Herbal Medications: It is best to stop any herbal remedies five (5) days before the procedure as many of them can thin the blood and increase the risk of bleeding during the procedure.

ADDITIONAL INFORMATION:

Approximately 3 business days prior to your procedure, you will be receiving an automated phone call from our Phone Tree system reminding you of your appointment. Please listen to this entire message and press the appropriate number for your response regarding your appointment. If you are not at home, Phone Tree will leave a message on your answering machine. Unless you want to cancel or reschedule your appointment, it is not necessary to call the office to confirm. We will assume you are keeping your scheduled appointment unless we hear from you.

You will also receive a call from St. Luke's GI/Endoscopy Lab a couple days prior to your appointment to go over your health history.

You may visit our website (www.gatewaygi.com) for more detailed information regarding the physician you will be seeing and other services offered.

HOW DID YOU HEAR ABOUT OUR PRACTICE:

Primary Care M.D. OB/GYN Internet Friend/Family Advertisement Other _____

NAME: MR./MRS./MS.

STREET ADDRESS:

CITY: STATE: ZIP:

SSN: DOB:

HOME PHONE NUMBER: ALTERNATE NUMBER:

EMPLOYER: OCCUPATION:

MARITAL STATUS: SPOUSES NAME:

EMERGENCY CONTACT: RELATIONSHIP TO CONTACT:

THE FOLLOWING IS REQUIRED BY THE STATE OF MISSOURI:

Hispanic or Latino Neither Hispanic or Latino

RACE:

White Black or African American American Indian or Alaska Native Asian Native Hawaiian/Pacific Island
 Other Multi-Racial (two or more races) Choose Not to Answer

MEDICAL INSURANCE INFORMATION

Primary Insurance Company	Phone Number
Policy/Id#	Group#
Relationship to policy holder	Policy Holder DOB
Secondary Insurance Company	Phone Number
Policy/Id#	Group#
Relationship to policy holder	Policy Holder DOB

Responsible Party

NAME: MR./MRS./MS.

STREET ADDRESS:

CITY: STATE: ZIP:

SSN: DOB:

HOME PHONE NUMBER: ALTERNATE NUMBER:

EMPLOYER: OCCUPATION:

RESPONSIBLE PARTY/GUARANTOR'S SIGNATURE

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS/RECEIPT OF PRIVACY PRACTICES POLICY

I hereby authorize the release of any medical information necessary to process my health insurance claims and request payment of benefits to Gateway Gastroenterology, Inc for services rendered. I permit a copy of this authorization to be in place of the original. I understand that I am financially responsible to these providers of service for charges not covered or denied by my insurance company. I further agree in the event of my non-payment, to pay the cost of collection and/or court costs and reasonable fees should this be required.

I have received a copy of Gateway Gastroenterology, Inc.'s Notice of Privacy Practices

SIGNATURE _____ DATE _____ SIGNATURE _____ DATE _____

GATEWAY GASTROENTEROLOGY, INC. MEDICATION SHEET

For Medical Records purposes, we will need you to provide us with a list of your current medications. This information is very important to us. Please complete this list below and bring it with you at the time of your appointment. Thank You!

Date _____

Medication Allergies and Reactions

	Medication (Include non-prescription and herbal supplements)	Dosage	Frequency (how often)
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

*If more space is needed, please continue on the back of this form.

Signature/Title/Date of RN Reviewing Medication List

PATIENT RIGHTS

Every patient has the right to be treated fairly, with respect and as an individual.

Patients are treated with respect, consideration, and dignity.

Patients are provided appropriate privacy.

Patient disclosures and records are treated confidentially, and except when required by law, patients are given the opportunity to approve or refuse of their release.

Patients are informed of their right to formulate an advanced directive, at the time the procedure is scheduled, and to appoint a designated representative to make healthcare decisions on their behalf to the extent permitted by law. This facility does not honor advance directives and the patient has the right to schedule their procedure at another facility.

Patients are provided, to the degree known, complete information concerning their diagnosis, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.

Patients are given the opportunity to participate in decisions involving their healthcare, except when such participation is contraindicated for medical reasons.

Patients are provided information about treatment alternatives and will be advised of the advantages and disadvantages of each.

Patients have the right to refuse to participate in experimental research.

Patients have the right to know in advance the type and expected cost of treatment.

Patients have the right to know that the physician that refers you to the Endoscopy Center may have ownership interest in this facility. You are free to choose another facility in which to receive services. You were informed both in writing and verbally prior to the date of service.

Patients have the right to be informed of the professional rules, laws and ethics that govern the organization and its employees.

Patients and families have the right to express grievances and suggestions to the organization. Every effort will be made to follow up on all grievances and suggestions. Patient care and satisfaction are very important to our entire staff.

PATIENT RESPONSIBILITY AND CONDUCT

To provide healthcare providers with information about any past illness, hospitalizations, medications and other health matters.

To ask questions if they do not understand instructions or explanations given by the healthcare providers and/or staff.

To keep appointments as scheduled and to telephone the office in case of a cancellation.

To follow healthcare providers instructions and plan of treatment.

To make payments for services rendered if a balance remains after insurance pays.

To discuss consequences of refusing treatment or not adhering to plan of treatment or leaving Against Medical Advice (AMA) with their physician.

To refuse to participate in experimental research, if that is their desire.

To refuse to allow care from a student or trainee, if that is their desire.

NOTICE

Anyone having concerns about the quality of care provided in this organization may report these concerns to the organization's management, the Missouri Department of Health and Senior Services, the Joint Commission or Medicare. A quality Incident Report Form is available upon request. You may choose to report anonymously or provide your name and contact information.

Facility Management

(800) 590-2713

The Joint Commission

JCAHO

One Renaissance Blvd.

Oakbrook Terrace, IL 60181

(800) 994-6610

Missouri Department of Health and Senior Services

Contact the Health Facilities Regulation Unit

P.O. Box 570

Jefferson City, MO 65102

(573) 751-6302

dhcc.mo.gov

You may also fill out a concern form online at

<http://www.dhss.mo.gov/AskUs.html>

Medicare

www.medicare.gov

(800) 633-4227