RYAN CRENSHAW, M.D.
21135 Whitfield Place, Suite 102
Sterling, VA 20165
703-444-4799

INSTRUCTIONS FOR UPPER ENDOSCOPY (EGD)

This procedure needs to be completed within 90 days of your last office visit.

**** Please read 2 weeks prior to your appointment. If you fail to follow the instructions and the procedure has to be cancelled, the cancellation fee will be charged.****

**** If you need to cancel your procedure, please let us know 5 business days prior to the procedure. If you fail to do so, you will be charged a $250.00 cancellation fee.****

**** You will receive a confirmation call from our office staff at least 5 days prior to your scheduled procedure(s). All procedures(s) must be confirmed in order to remain on the schedule. If you do not receive a call from our office, please contact us at 703-444-4799.**

1. If you take blood thinners such as Aspirin, Plavix, or Coumadin, Dr. Crenshaw may recommend for you to hold these medications 8 days prior to your procedure(s), depending on what agent you are taking.

   Patients on Coumadin (Warfarin): If approved by the prescribing physician (i.e. cardiologist/primary care provider), you will be asked to stop your Coumadin 5 days prior to your procedure(s). You will also be asked to obtain a PT/INR, PTT blood test the day prior to your procedure(s). If you did not receive an order for this blood test please contact our office at (703) 444-4799. Dr. Crenshaw will instruct you regarding the date to restart Coumadin (Warfarin) on the day of your procedure(s)

   Patients on Plavix (Clopidogrel): If approved by the prescribing physician (i.e. cardiologist/primary care provider), you will be asked to stop your medication 7 days prior to your procedure(s). Dr. Crenshaw will instruct you regarding the date to restart your Plavix (Clopidogrel) on the day of your procedure(s).

   Patients taking Aspirin: Please make sure one of the two boxes is checked off below. If not, please contact our office at (703) 444-4799.

   - ❑ Please continue to take 81 mg Aspirin or 325 mg Aspirin until the day of the EGD.
   - ❑ Please discontinue to take 81 mg Aspirin or 325 mg Aspirin until the day of the EGD.

2. If you are taking a PPI (Nexium, Prilosec, Aciphex, Omeprazole, Pantoprazole, Zegerid or Protonix), please follow instructions checked in the box below:

   - ❑ Please discontinue PPI for 2 weeks prior to the EGD. You may take Zantac 75mg or 150mg daily, with or without Maalox, up until the day prior to the procedure. This will help to obtain a more accurate result for the H. Pylori test.

   - ❑ Please continue taking the PPI until the day prior to the EGD.

3. It is highly recommended that you take your medication for **heart disease, high blood pressure and asthma** the morning of your procedure. Please take them 4 hours prior to your procedure that day with a small sip of water. All other medications should be brought to the hospital to be taken after our procedure.

(turn page over)

4. You may take other medications as you usually do, up to the day before your procedure, except for recommendations in paragraphs #1 and #2.

5. (a) If your procedure time is prior to 12 pm, **do not eat or drink anything after midnight the night prior to your procedure, except for medications as described in paragraph #4 above.**

   (b) If your procedure is scheduled 12 pm or later, you can consume up to 24 oz. of a clear liquid until 5 hours prior to your scheduled procedure time.

   SAMPLE MENU FOR CLEAR LIQUID DIET: White or grape cranberry juice, apple juice, tea, coffee (no milk), soup broth, Sprite, 7up, Ginger Ale, fruit-flavored ice.

6. You should not drive until the next day. The medication that you will receive during the procedure will impair your driving ability. Do not drive a car for at least 24 hours after the procedure. You must arrange for someone to pick you up after the procedure.

7. Medical clearance may be required prior to this procedure; you will be informed if you will need an EKG or other study prior to the procedure.

8. The hospital or surgery center will contact you before the procedure for a pre-operative interview. If you do not receive a telephone call 2-3 days prior to the procedure, please contact the appropriate hospital/surgery center at the telephone number provided at the time of your office visit.

9. The day of your procedure, please arrive one hour prior to your scheduled time.

DR. RYAN P. CRENSHAW, M.D.
21135 WHITEFIELD PLACE, SUITE 102
STERLING, VA 20156
(703) 444-4799

OPERATIVE REQUEST/CONSENT

1. I hereby request, consent to, and authorize Dr. Crenshaw (the "Practitioner") to perform the following procedure(s) along with surgical assistants selected by him: esophago-gastro-duodenoscopy, possible biopsy. Risk of drug allergy, over sedation, aspiration, bleeding, perforation and need for surgery have been explained. The Practitioner has advised me there is a small possibility of missing lesions on (the "Patient"):

   Please print your name:_____

2. It has been clearly explained to me that during the course of this operation some other conditions that have not been expected may present themselves. I recognize that if such conditions are discovered it will be necessary to do more than that which was specified in paragraph #1 above. I therefore authorize and request that the above named Practitioner and his surgical assistants perform such surgical procedures which in their best professional judgment will be effective in their attempt to heal and/or diagnose. This includes, but is not limited to, pathology and radiology. I further authorize Anesthesiologist to administer whatever anesthesia they feel is indicated and authorize the use of blood transfusion(s) when attending personnel feel such is required.

3. I fully understand that this operation, like any operation, is accompanied by some degree of risk and that no cure is guaranteed.

4. The nature of my (or the patient's) condition, the nature of the procedure(s) listed under paragraph #1 above, the risks involved and whatever other choices are available to me (or the patient), if any, have been explained to me by the Practitioner, and I have been given the opportunity to ask any questions that I may have regarding that explanation and my questions have been answered satisfactorily.

5. I am aware of the "Cancellation Policy" and understand that I will be held responsible for a $250.00 fee if notice is not provided at least **5 business days** in advance of scheduled date for procedure.

6. If your procedure is cancelled due to non-compliance with both verbal and written instructions given (for example, not complying with the clear liquid diet the day prior to your procedure), you will be charged the cancellation fee.

7. It is the patient's responsibility to contact their insurance to check coverage for the requested procedure(s), as well as obtaining the necessary referrals. It is also the patient's responsibility to notify our office immediately if your insurance changes, otherwise, the patient will be held responsible for any charges for the requested procedure(s).

_____ _____ _____ _____
Signature of Patient Date Signature of Witness Date

_____ _____
Signature of Parent/Guardian Date

PHYSICIAN'S STATEMENT

I have personally explained, in no technical terms, the proposed procedure to the patient, and/or Relative/guardian, the major risks or consequences of this procedure, and any alternative.

_____ _____
Signature of Physician Date PATIENT'S COPY

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_____ _____
Signature of Physician Date

DOCTOR'S COPY