

## COLONOSCOPY

**Thank you for choosing us to perform your colonoscopy. Please carefully read the following packet of information. If you have questions, please contact our office at (801) 408-7500, option 3 and ask to speak to our nurse, or your doctor's medical assistant. If you need to cancel or reschedule we require a 48hrs notice.**

Your colonoscopy is scheduled on \_\_\_\_\_ at \_\_\_\_\_ with Dr. Darcie Gorman, Dr. Melvin Kuwahara, Dr. Joseph Merrill, or Dr. Dan Collins

Please arrive at LDS Hospital at \_\_\_\_\_ for check-in. You need to check in ONE HOUR before your procedure time.

## QUESTIONS ABOUT YOUR COLONOSCOPY

### **Will my insurance company pay for my Colonoscopy?**

- It is your responsibility to check with your insurance provider regarding coverage and any pre-authorization that may be needed. **MAKE SURE YOU CALL YOUR INSURANCE COMPANY TO CONFIRM THEY PARTICIPATE WITH THE DOCTOR AND LDS HOSPITAL.** (Some insurance companies such as Blue Cross Blue Shield, Regence and Cigna as well as others, depending on your policy, **DO NOT** cover the LDS hospital, which would make you financially responsible.)

### **Where is my colonoscopy going to be done?**

- LDS Hospital (8th Avenue and C Street in Salt Lake City, Utah)
- You may park in the garage across the street to the west or there is also free valet parking between the Physicians Tower and LDS Hospital on 9th Avenue.
- Enter through the main doors on C Street go to the Patient Check-in (Registration) Desk, after you check in they will show you where the Endoscopy Reception is located. (Please understand that all procedure times are approximate: as often situations arise in the hospital which are beyond our control.)

### **Do I need someone to bring and pick me up from the Hospital?**

- **YES!** You will be receiving sedation so you **MUST** have someone there to drive you home. They do not have to stay while you are having your procedure, but the Endoscopy Center will need to have a phone number where they can be reached when your procedure is completed.

### **Is there anything I need to let Endoscopy know when I check in?**

- Please let them know, when you check in, if you are on any blood thinning medications, have a pacemaker, have diabetes, have problems with any of your heart valves, have a heart murmur, or have artificial valves or joints.

### **What is the preparation for my colonoscopy?**

- Stop eating all leafy and raw vegetables, seeds, and nuts, 3 days prior to your procedure.
- You will also need to take a bowel preparation. Please be sure to follow all instructions.

### **Things to Do:**

- 1) PLEASE CALL PRE-REGISTRATION AT LEAST 2 DAYS PRIOR TO YOUR PROCEDURE AT 801-442-8600 OR 1-800-269-8674.
- 2) Check with your insurance company to be sure that your physician and LDS hospital are participating on your insurance plan. Ask them to clarify your benefits as far as coverage of your procedure.
- 3) If you must cancel your appointment, please do so 3 days before your procedure. We have many patients waiting for an appointment. You may cancel by calling the office at (801) 408-8399, or LDS Hospital endoscopy at (801) 408-1057.
- 4) Complete the forms you have received in this packet and bring them with you to your procedure
- 5) AT LEAST 2 days before the procedure, pick up your bowel preparation from your pharmacy. Please follow all preparation instructions in this packet. It is important for you to have a clean colon to allow your doctor to find and remove polyps.
- 6) Arrange for someone to drive you home. Because you will receive medications to keep you asleep during the procedure, you will be considered legally impaired for 12 hours after the procedure.
- 7) Please check the list of blood thinning medications below. If you are taking any of them, please contact our office for directions about when to stop taking them.

### **Things to Bring:**

- 1) Photo ID
- 2) Insurance card, voucher
- 3) Completed health history and medication forms
- 4) Someone to take you home
- 5) Cash or credit card for co-pay (if required)
- 6) Copy of advanced directives
- 7) Something to do or read while you are waiting. Cell phone use is permitted in the waiting area, and we have free Wi-Fi throughout LDS hospital.

### **One day prior to your exam**

- You may have a normal breakfast.
- For lunch and dinner, clear liquids only. We suggest beef/chicken broth.
- You must drink clear liquids ONLY for the rest of the day and night before your procedure. (At least 1-2 quarts) This includes water, apple juice, Gatorade (not red, purple or blue), clear carbonated drinks, tea, Jell-o (not red, purple or blue). If caffeine is a must for you, ONE glass of BLACK coffee or caffeinated soda of your choice is permitted.
- Do not drink any liquid containing pulp, as well as milk, or cream.
- You may drink small amounts of Sprite, 7-Up or Ginger Ale along with the bowel prep solution. Please call the office or endoscopy if you are having trouble taking the bowel prep and we will do everything we can to help you complete the prep.
- There may be some discomfort as the bowel prep starts working. Use the restroom as often as necessary. Your stools should become loose and lighter in color (sometimes light yellow) until they become completely clear.

### **On the day of your Exam**

- Drink the rest of your bowel prep as directed the morning of your procedure.
- After you have finished the prep, nothing to eat or drink including water until after your exam.
- You may take essential morning medications with a sip of water.
- Please check with the office if you are diabetic and require insulin or oral diabetes medications. Please check your blood sugar before coming into the hospital for check in.

### **Medication Precautions**

This is a list of medications that may affect bleeding. If you are taking any of these, please check with the doctor who prescribes them for you and our office so we can determine when it is safe for you to stop the medication (s) before your procedure. If you are unsure if it is safe to continue of your home medications, please contact our office at least one week prior to your procedure.

- Lovenox
- Coumadin (Jantoven)
- Aspirin
- Eliquis (Apixaban)
- Pradaxa (Dabigatran)
- Advil
- Celebrex
- Ibuprofen
- Fish oil
- Heparin
- Warfarin
- Plavix (Clopidogrel)
- Xarelto (Rivaroxaban)
- Savaysa (Edoxaban)
- Naproxen
- Aleve
- Excedrin

### **Products you CAN use prior to colonoscopy:**

- Tylenol
- Acetaminophen

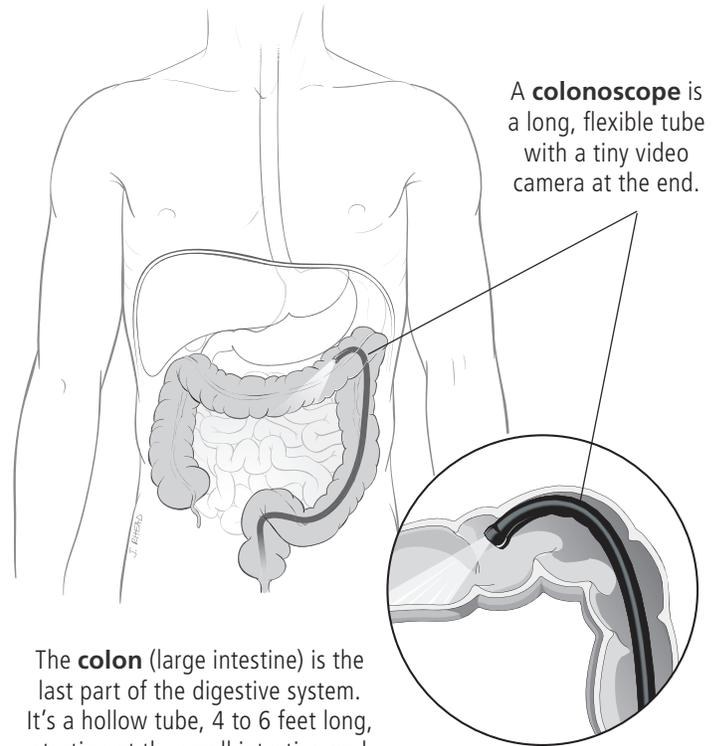
# Colonoscopy

## What is it?

**Colonoscopy** is a procedure to look at the inside of your colon and rectum. Your doctor inserts a **colonoscope**, a long, flexible tube with a tiny video camera at the end. The camera sends images to a monitor, allowing your doctor to see a variety of problems.

## Why do I need it?

- Colonoscopy is the best test to screen for colon cancer, precancerous growths, and polyps. If an abnormal growth or polyp is found, the doctor can remove it, take a biopsy, or recommend surgical removal later. Finding and removing growths may prevent cancer from developing.
- A colonoscopy also helps your doctor see other problems that may be causing abdominal pain, weight loss, or changes in bowel habits. This includes ulcers, narrowed areas, inflammation, or bleeding.



A **colonoscope** is a long, flexible tube with a tiny video camera at the end.

The **colon** (large intestine) is the last part of the digestive system. It's a hollow tube, 4 to 6 feet long, starting at the small intestine and ending at the rectum.

| Potential benefits  | Risks and potential complications  | Alternatives  |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Colonoscopy is the best test for detecting precancerous polyps and cancer.</li> <li>• The doctor can often remove polyps, perform biopsies, and treat problems during the procedure itself.</li> </ul> | <ul style="list-style-type: none"> <li>• Some people have cramps and abdominal swelling. This is caused by the air used to inflate the colon, and passes shortly after the procedure.</li> <li>• If your doctor takes a biopsy, you may see small amounts of blood in your stool after the procedure. If there's a lot of blood, you may need another colonoscopy, or possibly surgery.</li> <li>• There is a slight risk (1 in 3,000) of perforating the colon. This may cause bleeding or infection. If this occurs, you may need immediate surgery to repair the injury.</li> <li>• If the colon and rectum were difficult to examine or not completely empty, the procedure may not detect some problems.</li> <li>• As with any medicine, there's a slight chance you may have a reaction to the sedative.</li> </ul> | <ul style="list-style-type: none"> <li>• Barium enema</li> <li>• Flexible sigmoidoscopy (only looks at the lower part of the bowel)</li> <li>• Stool tests (not as sensitive, often used for yearly annual screening)</li> <li>• X-rays, CT scan, and ultrasound</li> </ul> |

## Preparing for a colonoscopy

- **Tell your doctor about any medications you take,** including prescriptions, over-the-counter medications, and herbal supplements.

### **If you are taking a blood-thinning medication**

(an anticoagulant), be sure your doctor knows about it. Contact your doctor or the people managing your blood thinner **at least a week before your colonoscopy.**

Ask whether you should stop taking this medication for a short time. Examples of blood-thinning medications include warfarin (Coumadin), rivaroxaban (Xarelto), apixaban (Eliquis), and dabigatran (Pradaxa).

- **Follow your doctor's instructions for cleaning out your colon.** Your doctor will recommend a special diet that will empty and clean out your colon before the procedure. This can take 1 to 2 days. Plan to stay at home during this time, as you will need to use the restroom often. Cleaning out your colon is a very important part of the procedure.
- **Arrange for a responsible adult to drive you home** after your colonoscopy.

## What happens before?

In most cases, you'll be given a sedative to help you relax. This is given through an intravenous line (IV) inserted into a vein in your arm.

## What happens during?

- The colonoscopy will last about 30 minutes.
- You'll lie on your left side while the doctor inserts the colonoscope into your rectum.
- A camera at the tip of the colonoscope sends images to a monitor so the doctor can look closely at the inside lining of your colon. The scope puts air into your colon to inflate it and gives the doctor a better view.
- Your doctor can also insert instruments through the colonoscope to remove polyps, take tissue samples, inject solutions, destroy abnormal tissue, or help widen openings.

## What happens after?

- You'll stay at the facility until you're partially recovered from the sedative. This usually takes about an hour. However, the sedative can take several hours (up to a full day) to wear off completely. Someone else will need to drive you home.
- You may feel bloated or have gas for a few hours. You may also see a small amount of blood with your first stool.
- You may discuss the results with your doctor after the exam or at a separate visit. Depending on the quality and findings of this exam, you may need follow-up procedures.

# SCREENING COLONOSCOPY

## BILLING QUESTIONS & ANSWERS

### When is a colonoscopy considered a “Screening Colonoscopy”?

Generally, there are two reasons we would consider it a “screening colonoscopy”:

- If you’re over the age of 50 and it’s your first colonoscopy.
- Any follow-up colonoscopies after the age of 50.
- As long as your first colonoscopy was done after you turned 50.
- As long as your last colonoscopy had no abnormal findings and no biopsy (*the removal and examination of tissue*) was done.

### When is a colonoscopy considered a “Diagnostic Colonoscopy” instead of a “Screen Colonoscopy”?

There are three reasons we could consider it a “diagnostic colonoscopy”:

- If you’re under the age of 50 and it’s your first colonoscopy.
- If your last colonoscopy had abnormal findings or required a biopsy.
- Once a polyp (*growth*) is found and is biopsied, we are no longer “screening” for something, because we found something; our treatment approach becomes “diagnostic” (*we have a diagnosis to follow up on*).
- If a doctor, such as a gastrointestinal (GI) physician, recommended a colonoscopy due to a medical condition such as diarrhea, constipation, abdominal pain, blood in stools, excessive gas/bloating, or any other abnormal gastrointestinal condition.

### Frequently asked questions:

- 1. Does this mean if I come in at age 50 for my initial “screening colonoscopy” and the doctor has to remove something he found and sends it to pathology, that my colonoscopy will no longer be considered “screening”?**  
No - If you are age 50 and this is your first colonoscopy, it will be considered a “screening colonoscopy”, no matter the findings. If your doctor finds something abnormal, you will be scheduled for a follow-up colonoscopy in three to five years (*depending on the pathology results*). The follow-up colonoscopy will be now considered “diagnostic” because you will now have a “diagnosis” that your doctor will be following up on.
- 2. If something is found/biopsied on the follow-up colonoscopy, will I ever be billed for a “screening colonoscopy” again?**  
Maybe - If something is found/biopsied on any colonoscopy, then the next colonoscopy will be considered a “diagnostic colonoscopy” because we will be following up on a “diagnosis”. If/when you have a colonoscopy that comes back normal with nothing to biopsy, your next routine colonoscopy will be considered a “screening colonoscopy” again.
- 3. Can’t I just ask the doctor to not take any biopsies if he finds something, so my colonoscopy will be billed as “screening”?**  
No - If something is found, the next colonoscopy will still be a diagnostic colonoscopy whether the biopsy is done or not. Your doctor may not ignore findings and should be given permission to remove anything suspicious in an effort to provide the best medical treatment for you.
- 4. Can the doctor simply not document that a biopsy was done, so my next colonoscopy can still be considered “screening”?**  
No - Your doctor is required to report his or her care and treatment as accurately as possible. The medical standard of care does not permit a doctor to withhold information.
- 5. Can the doctor change his notes on my procedure and re-submit the billing to my insurance?**  
Maybe - Your doctor’s notes are an important part of your medical care. If there is an error in the notes, the notes can be amended. Otherwise, the notes can’t be changed.
- 6. Can you change the coding so my insurance company will cover the procedure?**  
No - The coding must be accurate. Medical codes are an important way for doctors to communicate with staff and track your treatment. Only the correct code can be entered.

TODAY'S DATE / /

|  |   |                  |                        |                               |
|--|---|------------------|------------------------|-------------------------------|
| PATIENT NAME:                            | <input type="checkbox"/> M <input type="checkbox"/> F   | PREFERRED NAME:  | PHONE #                | AGE/DOB                       |
| REASON FOR ADMISSION / NAME OF PROCEDURE | PROCEDURE DATE  | SURGEON / DOCTOR | PRIMARY CARE PHYSICIAN | <input type="checkbox"/> NONE |
| <b>ALLERGIES/ REACTION</b>               | <input type="checkbox"/> NONE <input type="checkbox"/> MEDICATIONS <input type="checkbox"/> FOODS <input type="checkbox"/> LATEX <input type="checkbox"/> TAPE <input type="checkbox"/> OTHER |                  |                        | HT.<br>WT.                    |

**PREVIOUS HOSPITALIZATION(S) OR OPERATIONS**  
(INDICATE APPROXIMATE YEAR)

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HAVE YOU HAD A BAD REACTION TO ANESTHESIA?  YES  NO (Malignant Hyperthermia, Dark Colored Urine, Unexplained High Fever, Muscle Weakness after Procedure, Complications)

HAS A BLOOD RELATIVE HAD A BAD REACTION TO ANESTHESIA?  YES  NO

| HEALTH HISTORY   | YES | NO | QUESTIONS  |
|--|-----|----|--|
| <b>Have You Ever Had:</b>  |     |    |  |
| Diabetes      Controlled by: <input type="checkbox"/> Diet <input type="checkbox"/> Pills <input type="checkbox"/> Insulin   |     |    | Do You Currently Use Or Have A History Of Using Tobacco?<br>No. Of Yrs Used      Packs/Day      Date Quit<br>Tobacco Cessation Booklet <input type="checkbox"/> Given <input type="checkbox"/> Declined  |
| Hypoglycemia (Low Blood Sugar)   |     |    | Does Anyone In Your Household Smoke?<br>Do You Drink Alcoholic Beverages?<br>How Often      How Much   |
| Thyroid Problems   |     |    | Do You Have A History Of Substance Abuse Or Addiction?<br>Do You Have Any Of The Following:<br><input type="checkbox"/> False Teeth <input type="checkbox"/> Chipped Teeth <input type="checkbox"/> Braces <input type="checkbox"/> Bridges <input type="checkbox"/> Contact Lenses<br><input type="checkbox"/> Loose Teeth <input type="checkbox"/> Caps/Crowns <input type="checkbox"/> Retainers <input type="checkbox"/> Body Piercing <input type="checkbox"/> Hearing Aids |
| Heart Problems (Rheumatic Fever, Murmur, Chest Pain, Heart Attack, Irregular Heartbeat, Angina, Ankle Swelling, Valve Replacement, Pacemaker, Heart Failure, etc.) |     |    | Do you have any special needs / concerns?<br><input type="checkbox"/> Vision _____ <input type="checkbox"/> Hearing _____ <input type="checkbox"/> Speech _____<br><input type="checkbox"/> Language _____ <input type="checkbox"/> Translator Requested<br><input type="checkbox"/> Learning Needs _____ <input type="checkbox"/> Physical Limitations _____<br><input type="checkbox"/> Environmental Concerns (room temperature, lighting, etc.) _____                        |
| Blood Clots, Transfusion Problems, Or Bleeding Tendency (Hemophilia, Anemia, Sickle Cell Anemia, etc.)   |     |    | Do You Currently Need Assistance To Get Around The House, Do Errands, And Take Care Of Your Personal Needs?<br>Would You Like To Discuss Any Concerns, Fears Or Special Requests?<br>Do you use any of the following?<br><input type="checkbox"/> Oxygen <input type="checkbox"/> CPAP <input type="checkbox"/> BiPAP <input type="checkbox"/> Other _____   |
| High Blood Pressure  |     |    | Do you have any problems sleeping? <input type="checkbox"/> Breathing difficulties<br><input type="checkbox"/> Snoring <input type="checkbox"/> Pain <input type="checkbox"/> Insomnia <input type="checkbox"/> Need sleep aids<br><input type="checkbox"/> Up at night to use bathroom <input type="checkbox"/> Do not feel refreshed upon waking<br><input type="checkbox"/> Have been told breathing has stopped for short periods of time while sleeping                     |
| Stroke (Weakness/Numbness on one side, Difficulty Speaking, Loss of Vision, etc.)  |     |    | Women: Is There A Possibility You Are Pregnant?<br>Last Menstrual Period: _____<br>Women: Are You Breastfeeding?   |
| Seizures (Epilepsy, Convulsions, Blackouts, etc.)  |     |    | <b>IF THE PATIENT IS A CHILD: (17 &amp; under)</b><br>Was The Child Premature? Gestational Age: _____<br>Any Birth Defects Or Developmental Problems?<br>Any Immunization Problems Or Delays?<br>Any History Of Breath Holding, Breathing Problems, Croup or BPD?      RSV-Date Resolved _____   |
| Neurological Problems (Loss of Sensation, Numbness, Tingling, etc.)  |     |    | THIS FACILITY WILL NOT BE RESPONSIBLE FOR PERSONAL BELONGINGS AND VALUABLES. AS MANY BELONGINGS AND VALUABLES AS POSSIBLE SHOULD BE TAKEN HOME BY FAMILY MEMBERS.  |
| Severe Headaches   |     |    | <input checked="" type="checkbox"/> PATIENT'S OR SIGNIFICANT OTHERS SIGNATURE      RELATIONSHIP      DATE  |
| Glaucoma (Have you ever had or are you receiving treatment for)  |     |    | Hospital / Agency Interpreter name _____   |
| Lung Problems (Asthma, Chronic Cough, Pneumonia, Wheezing, Shortness of Breath, Emphysema, Abnormal Chest X-ray, Oxygen, Tracheostomy, Ventilator, etc.)           |     |    | Patient/parent declined hospital / agency interpreter (patient/parent has been advised that interpretation is free) and request made by the patient/parent to use (name) _____ (relationship) _____  |
| Tuberculosis / TB  |     |    | <input type="checkbox"/> Medication History Completed and Reviewed   |
| Sleep Apnea (Breathing Interruption During Sleep, etc.)  |     |    | Reviewed by _____ RN Date _____ Time _____   |
| Liver Problems (Jaundice, Hepatitis, etc.)   |     |    |  |
| Kidney, Bladder Or Prostate Problems (Infections, etc.)  |     |    |  |
| Stomach Problems (Ulcer, Hiatal Hernia, Reflux, Heartburn, Nausea/Vomiting, etc.)  |     |    |  |
| Bowel Problems (Irritable Bowel, Diverticulosis, Diarrhea, etc.)   |     |    |  |
| Back Trouble (Strain, Disc Problems, Numbness/Tingling of Hands or Feet, etc.)   |     |    |  |
| Broken Bones Of Head, Neck Or Spine, Restrictions In Movement Or Difficulty Opening Mouth (TMJ, etc.)  |     |    |  |
| Arthritis  |     |    |  |
| Muscle Disorders (MD, Myasthenia Gravis, Myositis, MS, etc.)   |     |    |  |
| Cancer (History or current treatment)  |     |    |  |
| Mental Health / Phobias (Anxiety, Depression, Psychosis, etc.)   |     |    |  |
| Mental Disability (Confusion, Memory Loss, Downs Syndrome, etc.)   |     |    |  |
| Skin Problems (Eczema, Fragile, Skin Breakdown, etc.)  |     |    |  |
| Pain In The Past Several Weeks Or That Limits Daily Activity   |     |    |  |
| Chronic Infection (MRSA, VRS, VRE, etc.)   |     |    |  |
| Other Medical Problems   |     |    |  |
| Nutrition Problems (Eating Disorders, Special Diet, TPN, etc.)   |     |    |  |
| Any Recent Illness, Cold, Cough or Fever? (Pneumonia, Flu, RSV, Strep)   |     |    |  |
| Recent Exposure To Any Communicable Diseases?  |     |    |  |
| <input type="checkbox"/> Influenza Vaccine (Last 12 Mo) <input type="checkbox"/> Pneumonia Vaccine   |     |    |  |
| <b>ADVANCE DIRECTIVES</b>  | YES | NO |  |
| Do you have any of the following types of advance directives? (If you mark YES to any, we need a copy to honor your wishes.)                                       |     |    |  |
| A Physician's Order (POLST, Life with Dignity Order, POST or an order from another state)  |     |    |  |
| An Advance Health Care Directive   |     |    |  |
| A Living Will  |     |    |  |
| A Durable Power of Attorney for Healthcare   |     |    |  |
| A Medical Treatment Plan   |     |    |  |
| If YES to any, was a copy requested?   |     |    |  |
| If YES to any, does this document still reflect your/patient's wishes?   |     |    |  |
| Would you like more information or assistance? <input type="checkbox"/> Info Given   |     |    |  |

**PATIENT HISTORY**

Pat His 50250  
IHC OR-475 / 8/11 ©2004, 2005, IHC Health Services, Inc.

Complete form within 24 hours of admission (see instructions on back of form)

|   |   |
|---|---|
| <input type="checkbox"/> Source of Medication List: _____<br><input type="checkbox"/> NO HOME MEDICATIONS<br><input type="checkbox"/> Unable to obtain medication history [give reason and follow-up plan (i.e. family bringing in)]: _____ | <input type="checkbox"/> NO KNOWN ALLERGIES<br>DESCRIBE REACTION or ALLERGY:<br>ALLERGIES (medications, food, vaccines, latex, dyes, etc.): _____ |
| Primary Care Physician: _____   | _____   |
| Patient's Home Pharmacy: _____  | _____   |

**CURRENT MEDICATIONS ON ADMISSION**

Include all prescriptions, over-the-counter medications, patches, inhalers, vitamins, teas, herbal, dietary, supplements

| Medication [Include dosage form if indicated (EC, XL, SR, etc.)] | Dose (amount) | Route (oral, topical, inject, etc.) | Frequency (how often taken, if taken regularly or only when needed) | ADMIT ONLY            |      | DISCHARGE ONLY           |      |
|--|---------------|-------------------------------------|---|-----------------------|------|--------------------------|------|
|  |               |                                     |   | When Last Taken: Date | Time | When Next Dose Due: Date | Time |
|  |               |                                     |   |                       |      |                          |      |
|  |               |                                     |   |                       |      |                          |      |
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|                                     |             |             |
|-------------------------------------|-------------|-------------|
| History obtained/reviewed by: _____ | Date: _____ | Time: _____ |
| History obtained/reviewed by: _____ | Date: _____ | Time: _____ |

**NEW MEDICATIONS TO BE CONTINUED AT HOME**

**HOME SCHEDULE**

|   |      |       |           |         |      |         |         |  |                |      |
|---|------|-------|-----------|---------|------|---------|---------|--|----------------|------|
| COMPLETE LIST INCLUDES YOUR CURRENT MEDICATIONS ABOVE AND NEW MEDICATIONS ADDED BELOW |      |       |           | MORNING | NOON | EVENING | BEDTIME | Crossed-out drugs on list should not be taken until you check with your Ordering Physician | Next Dose Due: |      |
| Medication  | Dose | Route | Frequency |         |      |         |         |  | Date           | Time |
|   |      |       |           |         |      |         |         |  |                |      |
|   |      |       |           |         |      |         |         |  |                |      |
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|   |      |       |           |         |      |         |         |  |                |      |

Not a Prescription

|                         |             |             |  |
|-------------------------|-------------|-------------|--|
| LIP/RN Signature: _____ | Date: _____ | Time: _____ | Patient given a copy and instructed to keep a complete list of medications with them and to give to other healthcare provide |
| LIP/RN Signature: _____ | Date: _____ | Time: _____ |  |

Stamp plate or Patient Name



**Medication History and Discharge Form**

Med Hist 50225



**AVENUES SURGICAL CENTER**

**EMERGENCY ROOM**  
Enter On East Side . . . . . L1

**CENTRAL TOWER**  
Access through main entrance  
Pulmonary . . . . . C6  
Sleep Services . . . . . C5

**NORTH ENTRANCE / NORTH WING**  
Infusion . . . . . N3  
Behavioral Health . . . N5 & N6  
Radiation Therapy . . . . N1

MEDICAL OFFICES

HUNTSMAN EDUCATION CENTER

PHYSICIAN OFFICE BUILDING

**V Valet Service**  
6 a.m. to 2 p.m.  
FREE (No tipping please)

**Intermountain<sup>SM</sup> LDS Hospital**  
8th Avenue and C Street  
SLC, Utah 84143 • 801-408-1100

**MAIN ENTRANCE / MAIN PATIENT TOWER**

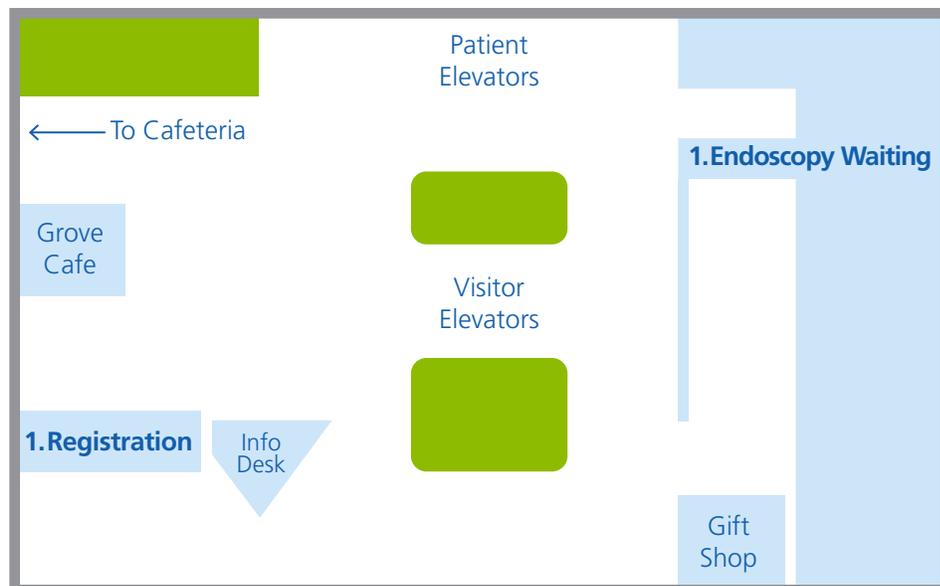
- Bone Marrow Transplant . . . E8
- EKG, Echo . . . . . E7
- Peripheral Vascular . . . . . E7
- Intensive Care Unit . . . . . E6
- Wound Care . . . . . E6
- Hyperbaric Medicine . . . . . E6
- Same Day Surgery . . . . . W3
- Surgical Unit . . . . . W6
- Orthopedic Unit . . . . . W7
- Joint Center . . . . . W7
- Medical, Surgical Unit . . . . W8
- Maternal Fetal Medicine . . . 4th

- Labor & Delivery . . . . . 4th
- Maternity . . . . . 4th
- Emergency Department . . . 1st
- Endoscopy . . . . . 1st
- Imaging Registration . . . . 1st
- MRI, CT, Mammography, Ultrasound, Angiography, Nuclear Medicine . . . . . 1st



## LDS HOSPITAL ENDOSCOPY

1. Check in at Registration
2. Check in at Endoscopy waiting area with receptionist



C STREET - MAIN ENTRANCE

PATIENT PARKING