Center for Digestive Health

Procedure Packet information

Thank you for choosing Center for Digestive Health. Our goal is to provide you with friendly, efficient service in a professional manner. This is a reminder for your upcoming procedure appointment.

You will receive a reminder in the mail with your time and date. Please read your preparation instructions at least one week prior to your procedure appointment.

IMPORTANT INFORMATION – PLEASE READ!

1. If you are taking **Coumadin (Warfarin), Plavix, Aggrenox, Pradaxa, Effient, Pletal, Brilinta, Eliquis** or **ANY** blood thinner for your heart or to prevent a stroke or blood clot – Call our office for instructions on the possibility of stopping the medicine. If you have not received a call please call our office.
2. If you take any dosage of Aspirin: **DO NOT** stop taking it! Please continue as normal. It's also OK to take Tylenol.
3. **STOP** taking any Iron pills, Pepto-Bismol, Fish Oil, Vitamin E or Herbal Medicines five (5) days before your procedure.
4. If you are **SICK**, have **ANY** cold symptoms, taking **ANTIBIOTICS,** pending **Stress or Heart Test** or have a major change in your medical history – please call our office immediately for instructions.
5. We need a 48 hour notice for any cancellations to avoid a charge of $100.00.
6. **Please call our billing department at 407-241-3279 to check if you are responsible of any payments the day of your procedure. Payments are due at time of service.**

***FINANCIAL POLICY:* Any Co-pay and Deductible will be collected upfront.**
Any questions regarding payment due at the time of service please contact our business office representatives to assist you with any questions: Please be advised we obtain AN ESTIMATE from your carrier…any additional questions please contact Your Insurance Carrier.

***CANCELLATION POLICY:* Cancellations require a 48hour notice.**
To Cancel a Procedure appointment, you must contact our dedicated Cancellation Line at 407-896-1726 ext 631…All appointments must be cancelled 48hours prior to scheduled time of arrival to avoid cancellation fee. There will be a $100 charge for non-emergency cancellations

If you have any questions or need assistance, please feel free to contact us at 407-896-1726

We look forward to providing you the best care you deserve

Procedure Information Packet

Patient instructions for your **UPPER ENDOSCOPY**

Your have been scheduled at The Center for Digestive Endoscopy for your procedure.
Address: 1817 N. Mills Ave. Orlando FL. 32803 Phone: 407-896-1726

For your procedure to be successful, please follow these bowel cleansing Instructions carefully.

5 DAYS BEFORE YOUR PROCEDURE:

1. Please read page 1 for **IMPORTANT** information.

DAY BEFORE YOUR PROCEDURE:

1. If you are a DIABETIC and take PILLS – DO NOT take them today or the day of your procedure.
    a. **For INSULIN dependent patients** – please call the doctor that controls your diabetes for instructions.
2. **NO SOLIDS AFTER 6PM. ONLY CLEAR LIQUIDS ARE OK AFTER 6PM.**
3. **NOTHING BY MOUTH AFTER MIDNIGHT.**

CLEAR LIQUIDS INCLUDE: ****NO RED****

- Water, coffee (black only) and Tea (sugar is ok)
- Clear fruit juices (Apple, White Grape and White Cranberry)
- Soda (with no caffeine), Gatorade, Popsicles, Jell-O (NO RED)
- Broths (no crackers or noodles)
- Sorbet and/or frozen ices – NO RED
- **DO NOT** drink any alcohol or alcohol containing products

DAY OF PROCEDURE:

1. **NOTHING BY MOUTH** – this includes Water.
2. You may brush your teeth – DO NOT swallow any water.
3. **DO NOT** chew anything (including gum), DO NOT use breath spray or eat candy or mints the morning of your procedure.
4. You **MUST** take your Blood Pressure, Heart, Seizure, Parkinson's & Asthma or Myastenia Gravis medications (if normally taken in the morning) **3 hours prior to arriving, with a small sip of water.**
5. You **MUST** have a responsible adult (over the age of 18) who will remain with you in the center and take you home.

****FAILING TO FOLLOW THESE INSTRUCTIONS WILL RESULT IN CANCELLING OF YOUR PROCEDURE****
(Cancellation fee will apply)

Patient Sign: _____ **Date:_____**