AdventHealth

Health Village Endoscopy
2415 North Orange Ave. Suite 201, Orlando, FL 32804
407-303-2530 | 407-303-2415 FAX

Procedure Appointment Information

Patient Name: _____

Procedure: _____ Physician: _____

You have been scheduled for a procedure at Health Village Endoscopy on _____.

Please arrive at _____ (AM/PM) for your procedure starting at approximately _____(AM/PM)

INSTRUCTIONS

1. Please get clearance to stop blood thinners from your cardiologist. All blood thinners will need to be stopped five (5) days prior to your procedure unless otherwise instructed by your physician (Aspirin, Coumadin, Effient, Plavix, Xarelto etc.)
2. The night before your procedure **DO NOT** eat or drink after midnight unless otherwise instructed by your physician or bowel prep instructions. This is including gum, candy, mints and water. Please follow prep instructions given to you by your physician. If you have questions about your bowel prep, please call your physician's office.
3. You may take your cardiac medications the morning of your procedure with just enough water to swallow.
4. If you are diabetic, please check your blood sugar prior to coming on the morning of your procedure. Please consult your physician about holding your insulin the morning of your procedure.
5. The following is a checklist of items you need to bring with you the day of your appointment.
   - ☐ Driver's License
   - ☐ Health Insurance Card
   - ☐ Completed Personal History Form (attached)
   - ☐ Medication and Herbal Supplements Worksheet (attached)
   - ☐ Recent records of pacemaker/defibrillator and EKG (if applicable)
6. Transportation: You are required to bring a responsible person to drive you home after your procedure. Please note that your procedure will be rescheduled if you do not make proper transportation arrangement. *A Taxi/Uber service not accompanied by a friend or family member is not an approved form of transportation.*
7. It is highly recommended that you **DO NOT smoke** the day of the procedure.
8. Your arrival time may change the day before your procedure.
9. Late Arrivals: Please note that arriving late may result in your appointment being moved to the next available procedure time slot or rescheduled.
10. Bowel Prep: If you have any questions related to your bowel prep, please call your gastroenterologist's office. If you have any questions or issues with your bowel prep medication prescription, please call your gastroenterologist's office.

AdventHealth Health Village Endoscopy

What to Expect on the Day of Your Procedure

- Please arrive at your scheduled time. We welcome your questions and will do our very best to keep you and your family informed.
- When checking in, have your insurance card and a photo ID. If you have the Health History and Medication Form filled out, provide this to the endoscopy department upon arrival.
- You will receive a card with a case number. This will help family members keep track of your progress by viewing the tracking board in the waiting area.
- After you have been registered, you will remain in the waiting area until it is time to go to Pre-Op. Your assigned nurse will escort you and one family member to Pre-Op.
- Please understand that you will be taken back according to your scheduled procedure time, not the time you arrived.
- Once in Pre-Op, you will be introduced to the clinical team and they will prepare you for the procedure.
- You will then be taken to the endoscopy procedure room. Procedures vary in time. Your nurse will provide a procedure time estimate.
- When the procedure is finished, you will be taken to the recovery area where your designated family member and the physician will join you.
- Once you are ready to go home, discharge instructions will be provided. You will be given a parking pass that covers the garage-parking fee.

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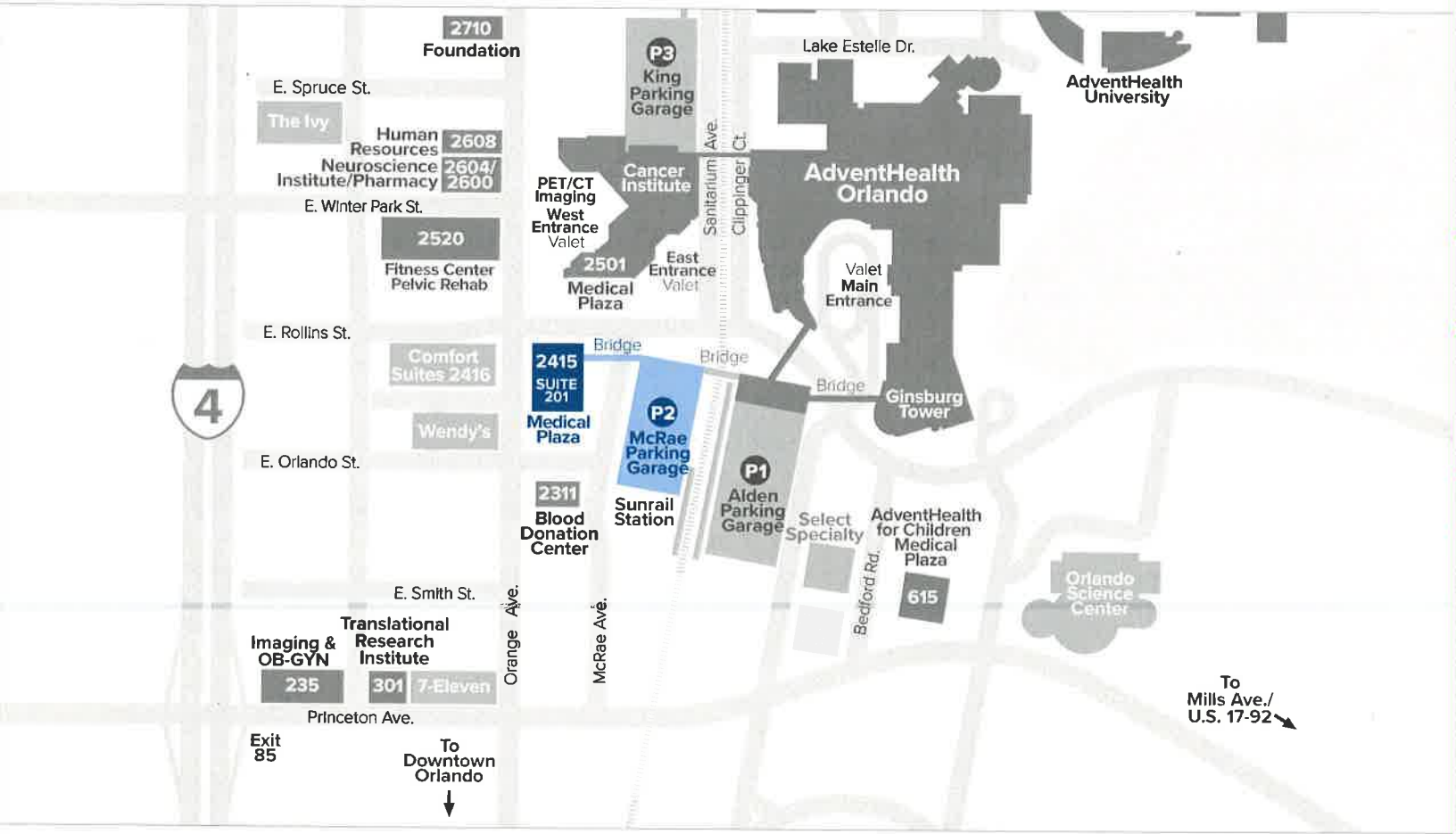
Directions

- From **I-4,** take **Exit 85.**
- Turn **east** onto **East Princeton Street.**
- At the 2nd traffic light, turn **left** onto **Orange Avenue.**
- At the 1st traffic light, turn **right** onto **Rollins Street.**
- Parking is available in the **McRae Avenue parking garage** located on the right.

Patients should arrive and will be discharged on the **3rd floor of the McRae Avenue parking garage.**

The walkway on the 3rd floor leads directly to **Suite 201, Health Village Endoscopy.**

Note: building opens at **6 am.**



AdventHealth complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número siguiente 407-303-3025.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele nimewo ki anba an 407-303-3025.

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DNA Analysis Testing Information Brochure

What is DNA analysis?
Genes are made up of DNA and are the "blueprints" for our bodies. A biopsy or "sample" may be taken from your body during a procedure or surgery or when you go to the laboratory. These samples may be body tissues, cells or fluids such as saliva, nose or throat secretions, blood, or urine.

The sample(s) is sent to a laboratory for DNA analysis testing. The laboratory is often one separate from AdventHealth. The laboratory sends the test results to your physician(s) and your physician(s) will tell you your test results. Test results from DNA analysis are also commonly referred to as genetic information.

What are the benefits of DNA analysis?
- It enables physicians to provide the most effective treatments for cancer, and in most cases, DNA analysis is now a standard of care for treating cancer.
- It is the best test for diagnosing certain genetic conditions such as cystic fibrosis, sickle cell anemia, or familial hypercholesterolemia.
- It can tell you that you have an increased risk of developing a condition later in life (such as colon cancer or coronary artery disease). As a result of knowing this, you may talk to your physician about how to lower your chance of developing the disease.
- It can provide useful information when planning for future children.
- It may be helpful for your other family members since genetic conditions can "run in families".

What are the risks of <u>not</u> having DNA analysis done on your sample for treatment?
- Failure to obtain DNA analysis for cancer treatment could result in not receiving the best and most effective treatment for cancer.
- Failure to obtain DNA analysis for cancer treatment could result in death.
- Failure to know about medical conditions that could exist and losing the ability to prevent or lower the likelihood of the medical condition happening.

What are the risks of DNA analysis?
- Taking the sample may be uncomfortable for you. For example, if a nose swab is done, it may cause a nosebleed. If a blood sample is taken, it may cause bruising or minor bleeding. It is possible that testing may need to be repeated and that more biopsies will be needed.
- Test results may not show what caused your health care condition or may provide only limited information about an inherited condition that could cause a health problem in the future.
- Test results may not be correct because of sample mislabeling, contamination or problems with computer software. This could lead to an incorrect diagnosis.
- You and your family members may experience anxiety before, during, or after a DNA analysis. You and your family may also experience feelings of anger, depression or guilt about the test results (for example, a DNA analysis could show that your father or mother is not your biological father or biological mother).
- Test results may change over time as technology and scientific knowledge develops. A DNA analysis test result is a 'snapshot in time' and your samples or test results might not be re-analyzed in the future.

Where are leftover samples stored and how are they used and shared with others?
Federal law requires CLIA laboratories to retain leftover samples for 10 years to validate the test results. These samples are stored in a database or biorepository. Leftover samples may be used and shared with others for test validation or other uses allowed by law or as explained in the AdventHealth Joint Notice of Privacy Practices.

Downtime Outpatient Personal Health History – Adult

General Information

Information Provided by (Relationship):

☐ Patient

☐ Other _____

Reason for Hospital Visit:

Health Care Surrogate or Next of Kin: Name: _____

Relationship: _____

Preferred Pharmacy Name/Phone# _____

Obstructive Sleep Apnea

Patient to Receive Sedation: ☐Yes ☐ No *If "Yes", must complete Obstructive Sleep Apnea (OSA) Screen*

Have you been diagnosed with Obstructive Sleep Apnea (Confirmed by Sleep Study)? ☐ Yes

Do you use a CPAP or BiPAP machine at home? ☐Yes (3) ☐No (3) ***If "Yes" OSA Risk Screen: Positive***
Did you bring it to the hospital? ☐Yes ☐No

Are you compliant with the use of your CPAP/BiPAP machine? ☐ Compliant (regular use) ☐ Non-compliant

Have you been diagnosed with Obstructive Sleep Apnea (Confirmed by Sleep Study)? ☐ No

Stop-Bang Scoring Questionnaire

Snore:	Do you snore loud enough to be heard through closed doors?	☐Yes (1) ☐No (0)
Observed:	Have you been told you stop breathing during sleep?	☐Yes (1) ☐No (0)
BMI:	Is your Body Mass Index (BMI) more than 35 Kg/M2?	☐Yes (1) ☐No (0)
Tired:	Do you feel sleepy, fatigued or fall asleep easily during the day?	☐Yes (1) ☐No (0)
Pressure:	Do you have high blood pressure?	☐Yes (1) ☐No (0)
Neck	Is your neck size greater than 17 inch or do you wear XL shirt?	☐Yes (1) ☐No (0)
Age	Are you age 50 years or older?	☐Yes (1) ☐No (0)
Gender	Male?	☐Yes (1) ☐No (0)

Total Score_____

Total Score of 1-2 = OSA Risk Screen: Negative

Total Score of 3 or higher = OSA Risk Screen: Positive (Risk Screen Positive - enter Outpatient OSA Risk Protocol, Adult 959-3086B)

Allergies (Food, Drug, Environmental)

Allergy	Reaction	☐ No Known Allergies
_____	_____	
_____	_____	
_____	_____	

Patient Label

Medical History

Do you have any medical devices, pumps, patches in or on your body: ☐ Yes ☐ No

Type: _____

***If Meds delivered by pump/patch nurse to record on Medication History**

Medical: ☐ No past medical history

_____ Year_____
_____ Year_____
_____ Year_____
_____ Year_____

Surgical: ☐ No past surgical history

_____ Year_____
_____ Year_____
_____ Year_____
_____ Year_____

Family History: ☐ No past family history

Relationship_____ History of:_____Health Status_____
Relationship_____ History of:_____Health Status_____
Relationship_____ History of:_____Health Status_____

Social History

Tobacco:
Current Use:_____Type:_____Frequency/Years:_____Details_____
Alcohol:
Current Use:_____Type:_____Frequency:_____Details_____
Substance Abuse:
Current Use:_____Type:_____Frequency:_____Details_____
Employment/School:
Status:_____Details:_____
Exercise:
Duration:_____Type:_____Frequency:_____Details_____
Home/Environment:
Lives with:_____Living Situation:_____Home Equipment:_____
Nutrition/Health:
Details:_____
Sexual:
Details:_____
Other:
Details:_____

PHH completed/reviewed by: _____ Date_____Time_____

Staff Name Printed: _____

Patient Label

Communicable Disease Screening

Infectious Disease Risk factors/ Symptoms

Active TB or History of TB (even if on meds)	☐Yes	☐ No
Fever	☐Yes	☐ No
Cough	☐Yes	☐ No
Shortness of breath	☐Yes	☐ No
Sore Throat	☐Yes	☐ No
Diarrhea	☐Yes	☐ No
Rash	☐Yes	☐ No
Joint Pain	☐Yes	☐ No
COVID-19 close contact w\lab confirmed pt. in last 14 days	☐Yes	☐ No

Cough greater than 2 weeks ☐Yes ☐No

Unexplained Diarrhea (watery stool) within the past 5 days ☐Yes ☐No

Explained Diarrhea includes Currently on laxatives Irritable Dowel Disease, Short bowel Syndrome. Etc.

Contact precautions if yes to Diarrhea

(ILI Symptoms: Temp of 100.5F or greater with cough and/or sore throat)

Influenza like illness symptoms ☐Yes ☐Criteria not met.

If answer yes, Initiate Droplet Precautions and place patient in private room. If private room is not available, place patient behind closed curtain.

*Indicates consults / departments must be contacted during down time and when down time completed entered in *i*- Extend

Signs and Symptoms, Risk factors — Total points related to questions 1-10 (No =0)

1. Active TB or history of TB (even if on meds)?	☐Yes (5)	☐No	
2. Cough greater than 2 weeks?	☐Yes (2)	☐No	
3. Fever and or chills and or night sweats?	☐Yes (2)	☐No	
4. Unexplained weight loss of greater than 10 lbs. in 30 days? *	☐Yes (2)	☐No	if yes, consult Nutritional Services
5. Bloody sputum?	☐Yes (2)	☐No	
6. Immune compromised (HIV, Cancer)?	☐Yes(2)	☐No	
7. Jail in the past 2 years?	☐Yes (2)	☐No	
8. Recent exposure to TB?	☐Yes (2)	☐No	
9. Foreign born?	☐Yes (2)	☐No	
10. Homeless or in shelter?	☐Yes (2)	☐No	* Points total _____

* If total points equal to or greater than 5, order airborne Precautions and consult infection control

Note to physician regarding patients need for TB work up ☐ Done

☐ Isolation type ☐ Standard Airborne ☐Contact ☐Droplet

Patient Label

Personal Health History Downtime Form
Communicable Diseases TB Screen continued

*Indicates consults / departments must be contacted during down time and when down time completed entered in *i*- Extend

Recent Travel

☐ No recent travel
☐ Travel within the last 14 days
☐ Travel within the last 30 days

Travel Locations

☐ Continental US
☐ Outside Continental US

Continental US Travel Locations

_____
_____
_____

Outside Continental US travel locations. *If Multiple locations, select highest appropriate answer on list below additional information can be added in travel comment PRN*

☐ Arabian Peninsula = Bahrain, Oman, Qatar, Saudi Arabia, United Arab Emirates or Yemen

☐ COVID-19 risk area _____

☐ China ☐ Brazil ☐ Zika risk identified area (other than Brazil) *to be completed after down time Use the Link to the CDC website*

☐ Africa ☐ Australia ☐ Canada ☐ Europe Other _____

Africa travel details, Congo _____ Other _____

Positive screen for travel related infectious disease / base results on charting

☐ MERS (Arabian Peninsula travel + fever, cough, shortness of breath) ☐ COVID-19 (China Travel + fever, cough, shortness of breath)

☐ Ebola travel risk (Congo) ☐ Zika (travel risk + 2or more : fever, rash, red eyes, pain ☐ Yellow fever (Brazil travel + fever)

Please re-confirm your documentation If "MERS" or COVID-19 ," Mask and isolate Patient. Call Infection Prevention @ 407-580-6235

Automated Page will also be sent

PHH completed/reviewed by: _____ Date_____Time_____

Staff Name Printed: _____

Patient Label