

## Preparing for your Sigmoidoscopy Procedure

**Please read all the instructions in this packet at least 1 week before your Sigmoidoscopy.**

Thank you for choosing the Gastroenterology Associates at Mass General Hospital for your colonoscopy. All instructions must be followed, or your colonoscopy may be canceled. For more information, review the Frequently Asked Questions section of our website:

[www.massgeneral.org/medicine/gastroenterology/about/frequently-asked-questions](http://www.massgeneral.org/medicine/gastroenterology/about/frequently-asked-questions)

Informed Consent: [https://www.youtube.com/watch?v=AtpbIg\\_G0HM&feature=youtu.be](https://www.youtube.com/watch?v=AtpbIg_G0HM&feature=youtu.be)

**MGH Gastroenterologist name:**

**Patient name:**

**Date and arrival time:**

*If the procedure is rescheduled, this date and time will no longer be accurate.*

**Procedure Location:**

Location--

*Please note: There is more than one location for MGH colonoscopy procedures.*

If you must cancel, please call us **at least 1 week before** your appointment at 617-726-7663. If you cancel late, we may not be able to reschedule your appointment.

## Plan ahead

- Call and check with your health insurance company directly if your procedure will be covered.
- **For your safety, you must have a responsible adult, 18 years old or older, to take you home after your procedure or your procedure will be canceled.**
  - Public transit, taxi, or rideshare services (Uber, Lyft, etc. are not acceptable)
- If you use home oxygen, use CPAP daily, or have an implantable cardiac defibrillator you must be scheduled at the Blake building
  - Call 617-726-7663 if you are scheduled at a different location.
- **Purchase 2 Fleet saline enemas and Milk of Magnesia.**



## Medications

- **Aside from the medications below, we recommend you take all home medications as usual** with water, at least 2 hours before your arrival time
- If you take blood thinners, we recommend you continue them unless your Gastroenterologist tells you to stop
- Contact your prescribing doctor about the suggested changes below
  - Continue taking Metformin or Metformin XR as prescribed.

<b>Stop 5 days before</b>	<ul style="list-style-type: none"> <li>• Iron containing vitamins (Ferrous Gluconate, Multivitamins)</li> <li>• Liquid antacids (Gaviscon, Gelusil, Maalox, Mylanta, Rolaids, Pepto-Bismol)</li> </ul>
<b>Stop 4 days before</b>	<ul style="list-style-type: none"> <li>• Etugliflozin (Steglarto, Steguian, Segluromet)</li> </ul>
<b>Stop 3 days before</b>	<ul style="list-style-type: none"> <li>• Canagliflozin (Invokana, Invokamet)</li> <li>• Dapagliflozin (Farxiga, Xigduo XR)</li> <li>• Empagliflozin (Jardiance)</li> </ul>
<b>Day of procedure</b>	<ul style="list-style-type: none"> <li>• If you take insulin, only take ½ of dose</li> </ul>

**Two (2) Days Before Your Exam**

Take 4 tablespoons of Milk of Magnesia at bedtime.

**One (1) Day Before Your Exam**

Only have clear liquids for dinner and leading up to procedure.

Clear liquids- Items that are see through and liquid at room temperature. Please avoid any red, purple, or orange liquids.

Examples: Water, tea, black coffee, apple juice, white grape juice, sodas, and sports drinks like Gatorade

**Jell-O and Broth are not considered clear liquids. If you have Jell-O or broth the day of your procedure, it will be canceled.**

**Day of Procedure**

- **Two hours before you leave home**
  - Take the first Fleet Saline enema.  
1/2 hour later, take the second enema.
- **Two hours before scheduled arrival time**
  - Stop drinking all liquids (including your laxative prep)
  - Don't chew gum or eat any food
  - Your procedure will be postponed or canceled if you drink liquids, chew gum, eat hard candy or eat food within 2 hours of your scheduled procedure.

# The Day of Your Flex Sig Procedure

## Bring these things with you to your procedure

- ☐ Your photo identification
- ☐ The name and phone number of your escort
- ☐ You may wear your wedding rings but no other jewelry.

## The day of your procedure

- The time for your appointment is earlier than the time your procedure will start so you can get ready.
- Before the procedure, we will review the procedure with you and ask you to sign a consent form.
- Most procedures take about 3 hours. We make every effort to keep on time, but sometimes there are delays.

## After the procedure

- Most people need to rest at home for the remainder of the day. Don't drive or operate any machines on the day of your procedure. Avoid making any important decisions. Avoid drinking alcohol.
- You can go back to eating as you normally do right away.
- You will get a letter in the mail with your test results within 2 weeks after your procedure. If you have a Partners HealthCare Patient Gateway account, you can also see your results there.

### Remember

- You cannot drive after your procedure.
- We will have to cancel your procedure if you do not have an adult escort to meet you in the endoscopy unit and bring you home.
- Your escort should be able to pick you up 30 minutes after we call them.

For any questions about this information call 617-726-7663.

Hospital:

## Patient Identification Area

PATIENT MUST BE IDENTIFIED BY:

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_ (MM/DD/YY)

MEDICAL RECORD NUMBER: \_\_\_\_\_

**CONSENT FOR PROCEDURE**

I allow \_\_\_\_\_ to perform the procedure

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Operative Site: \_\_\_\_\_

If laterality applies: ☐ Right ☐ Left ☐ Both Sides ☒ NA

I have been told the risks and benefits of the procedure. I also know that there are other choices. I understand the risks and benefits of these other choices. I understand what could happen if I do not have the procedure.

I understand that medicine and surgery are not exact. I understand there are no guarantees for the outcome of this procedure.

I understand that loss of blood, infection, or pain may happen with any procedure.

My care team explained the risks below:

Sometimes patients need to be put to sleep for a procedure. This is called sedation. My doctor discussed the risks of sedation. These risks include slower breathing and low blood pressure. If these happen, I might need treatment. I understand there may also be other risks.

I understand that I might lose blood during the procedure. If that happens, I may need blood products. This could be during or after the procedure. If I do not want blood products, I will fill out a separate form.

I understand that other people may be in the room during my procedure. This includes observers or people who work for medical equipment and device companies. They will be observing or giving advice.

The hospital may take photos or recordings of my procedure. These photos or recordings will be used for education, research, and other healthcare operations. My identity will not be revealed when these are used.

The hospital may throw away blood or other samples taken from me during the procedure. The hospital or its partners may also use the samples. They may be used for activities that support research, education, or other parts of the hospital's mission.

Hospital: \_\_\_\_\_

## Patient Identification Area

PATIENT MUST BE IDENTIFIED BY:

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_ (MM/DD/YY)

MEDICAL RECORD NUMBER: \_\_\_\_\_

**CONSENT FOR PROCEDURE**

A team will work together to do my procedure. My doctor told me about the senior attending and others who might help. The team might have doctors, advanced practice providers, or students. I know that other people besides the senior attending might do parts of the procedure. This includes but is not limited to:

- Opening or closing the surgery spot.
- Collecting grafts.
- Removing or moving tissue.
- Doing exams like breast, pelvic, prostate, or rectal exams, if needed.

The roles and names of other people in the procedure are listed below. I know that other medical staff not listed might also be part of my surgery. I will learn their names later.

Role of Practitioner (check all that apply)	Name of Practitioner if known
<input type="checkbox"/> Fellow.	
<input type="checkbox"/> Resident. Specify Year: _____	
<input type="checkbox"/> Physician Assistant	
<input type="checkbox"/> Advanced Practice Nurse	
<input type="checkbox"/> Other, please specify: _____	
<input type="checkbox"/> Other, please specify: _____	

- ☐ My doctor has told me that my procedure will overlap with another procedure they are doing. I understand that my doctor will be in the operating room during the most important parts of my procedure. I understand that they may not be there for the whole procedure. I understand that my doctor or another qualified doctor will be available immediately, if needed, during my procedure.

I had a chance to ask questions about the risks, benefits, and side effects of the procedure. I was also able to ask questions about the chances of achieving the goals of the procedure and other options. All my questions were answered. I agree to the procedure.

\_\_\_\_\_  
Patient/Legal Surrogate Decision Maker Signature      Printed Name      Date      Time      AM  
PM

\_\_\_\_\_  
Practitioner Obtaining Consent Signature      Printed Name      Date      Time      AM  
PM

**Attending Physician/Primary Practitioner Attestation**

I confirm that I explained all relevant parts of this procedure. This includes the indications, risks, and benefits. I compared other approaches with the patient or legal surrogate decision maker. I answered their questions. I provided information about other medical professionals who will be present during the surgery.

\_\_\_\_\_  
Attending/Practitioner Signature      Printed Name      Date      Time      AM  
PM

If interpreter was used provide name or number of interpreter: \_\_\_\_\_

**Telephone/Verbal Consent** (applicable if the patient is incapacitated)

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM PM Reason for Telephone/Verbal Consent: \_\_\_\_\_

Legal Surrogate Decision Maker Name: \_\_\_\_\_

Consent Received by: \_\_\_\_\_

Consent Witnessed by: \_\_\_\_\_