

**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 these 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 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. \*\***

**\*\* 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. \*\***

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 which agent you are taking.

Patients on Coumadin (Warfarin): If approved by the prescribing physician (i.e. cardiologist or primary care provider), you will be asked to stop the 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 or 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 Aspirin at the current dose daily, including the day of the EGD. All medications must be taken at least 4 hours prior to the scheduled procedure time with a small quantity of water.
- Please stop taking Aspirin 7 days prior to the date of the EGD.

(turn page over)

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

- Please stop taking your PPI for 4 weeks prior to the date of your EGD. You may take Pepcid or Tagamet, with or without an antacid such as Maalox, daily, including the day of your procedure.
- Please continue taking the PPI daily, including the day of your EGD. All medications must be taken at least 4 hours prior to the scheduled procedure time with a small quantity of water.

It is highly recommended that you take your medication for **heart disease, high blood pressure and asthma** daily, including the day of your procedure. You may take your regularly scheduled medications daily, including the day of your procedure, with the exception of special instructions as described in paragraphs #1 and #2. Medications must be taken 4 hours prior to your scheduled procedure time with a small quantity of water. All other medications should be brought to the hospital to be taken after your procedure.

3. **Please stop consuming solid food after 9 PM the night prior to your procedure.** You are allowed to consume clear liquids listed below until 4 hours before your procedure time. In addition, you can take your medications on the day of the procedure with a clear liquid. Medications must be taken at least 4 hours prior to your procedure time. Please do not consume any liquids or medications after the time corresponding to 4 hours prior to your 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.

4. You should not drive until the next day. The medication that you will receive during the procedure will impair your driving ability. You must arrange for someone to pick you up after the procedure.

5. 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 hospital/surgery center at the telephone provided at the time of your office encounter.

6. On the day of your procedure, please arrive at the facility according to the box checked below:

- Loudoun Ambulatory Surgical Center: 1 hour prior to your procedure time
- Inova Loudoun Hospital: 1.5 hours prior to your procedure time

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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 with possible biopsies, dilation of a narrowing, and control of bleeding. 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"):
2. Please print your name: \_\_\_\_\_
3. 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 preform such surgical procedures which in their best professional judgement 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.
4. I fully understand that this operation, like any operation, is accompanied by some degree of risk and that no cure is guaranteed.
5. 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,
6. 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 of procedure.
7. 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.
8. It is the patient's responsibility to contact his/her insurance to check on coverage and his/her out of pocket expenses for the requested procedure(s). In addition to obtaining the necessary referrals. We also request that you notify our office immediately if your insurance policy changes. Otherwise, you will be held responsible for any charges for the 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
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DOCTOR'S COPY