MASSACHUSETTS
GENERAL HOSPITAL
GASTROENTEROLOGY

Preparing for your Endoscopy Procedure

Thank you for choosing the Gastroenterology Associates at Mass General Hospital for your Endoscopy. We want to make sure your procedure goes as smoothly as possible. **Please read all the instructions in this packet at least 1 week before your procedure.** All instructions must be followed or your endoscopy may be cancelled. If you have any other questions, call us at 617-726-7663.

MGH Gastroenterologist name and phone number:

Patient name:

Scheduled procedure:

Procedure location:

Please Note: There is more than one location for MGH endoscopy procedures. Your location is listed here.

Date and arrival time:

Please note: Your arrival time is different than the start time for your endoscopy so you have time to get ready for your procedure.

- **Most patients are ready for discharge within 3 hours of the scheduled arrival time but occasionally unforeseen events occur that result in delays. You will be informed of any potential delays when you arrive.**
- **Your escort should be available to meet you within 30 minutes after we call.**

** Please refer to the day of procedure instructions attached with your prep for important covid pre-procedural related inquiries.*

Plan ahead

- ☐ Update your MGH registration information by calling 866-211-6588.
- ☐ If you have questions about the coverage for your procedures, please call and verify with your insurance company directly.
- ☐ Sign up for a Partners HealthCare Patient Gateway account if you do not have one. It will help with communicating with us. You will be able to see your test results in Patient Gateway within 2 weeks of the procedure.
- ☐ Arrange for an adult escort to take you home after your procedure.
- ☐ Please make sure to log into your Patient Gateway account to complete your Pre-Procedure Evaluation (PPE) Questionnaire at least 3 days prior to your procedure.
- ☐ If your procedure is scheduled at Charles River Plaza (165 Cambridge St) and you use CPAP, home oxygen or have an implantable cardiac defibrillator, call so your exam can be rescheduled in the Blake Building.
- ☐ Please note that MGH policy requires that women, ages 11-55 years old have a pregnancy test prior to having any endoscopic procedure. When you arrive for your procedure, a registered nurse will screen you for the test and if needed, request that you provide a urine sample.
- ☐ Read the information about the day of your procedure in this packet. It will tell you what to bring.

It is very important that you keep this appointment. **If you must cancel, please call us at least 5 business days before your appointment** by calling 617-726-7663. Calling ahead allows us to reschedule your appointment and give that slot to another patient. **If you cancel late, we may not be able to reschedule your appointment.**

For driving directions, please visit the MGH Parking and Visitor Information website at www.massgeneral.org/visit. If you are using GPS, please make sure to use the correct zip code.

For more information and frequently asked questions, please visit our website www.massgeneral.org/endoscopy.

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EGD Preparation Instructions

IMPORTANT- Please read these instructions at least 1 day before your endoscopy

Day of Your Upper Endoscopy (EGD)

❑ **You may not eat any food on the day of your procedure.**
You may drink clear liquids. Clear liquids include water, tea, black coffee, clear broth, apple juice, Gatorade, soda, Jell-O.

❑ **Stop clear LIQUIDS 2 hours before your procedure.**
except for small amounts of water with medications.
Do not have gum or hard candy

❑ **Take all of your usual medicines including medicines for high blood pressure with a small sip of water.**

Medications

- If you are taking Canagliflozin (Invokana), Canagliflozin and Metformin (Invokamet), Dapagliflozin (Farxiga), Xigduo XR Dapagliflozin and Metformin extended-release, or Empagliflozin (Jardiance), please stop it at least three days before your GI procedure. If you are taking ertugliflozin (Steglatro, Stegujan, or Segluromet), please stop it at least four days before your scheduled procedure. Make sure to contact your primary care physician or diabetes doctor about the suggested changes above and get their guidance as well.
- If you take insulin, we usually recommend that you take ½ your normal dose on the day of the procedure.
- If you take blood thinners, we recommend you take them unless your MGH Gastroenterology doctor told you to stop taking them.
- Aside from the medications above, we usually recommend you take all home medications as usual with water.

The Day of Your Endoscopy 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. (see last page)
- Most procedures take about 3 hours. We make every effort to keep on time, but sometimes there are delays.
- We will call your escort 30 minutes before you are ready to leave.

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.

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CONSENT FOR PROCEDURE

Patient Identification Area
PATIENT MUST BE IDENTIFIED BY
NAME AND MEDICAL RECORD NUMBER

I hereby authorize ______________________________ to perform the following procedure(s)

Procedure Esophagogastroduodenoscopy with possible biopsy (EGD)

Site: Massachusetts General Hospital

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

I have been informed of 1) the potential risks and benefits of the procedure(s); and 2) the risks and benefits of the alternatives, including the consequences of not having the procedure(s).

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the proposed treatment(s) or procedure(s).

Further I am aware that there are possible risks, such as loss of blood, infection or pain that may accompany any surgical, diagnostic or therapeutic procedure. The following additional risks were explained to me:

Esophagogastroduodenoscopy (EGD) or upper gastrointestinal endoscopy is an important technique for examining the upper digestive tract. Although it is extremely safe a few complications are inherent to the procedure. The most common problem is a drug reaction which usually manifests itself as a local irritation to the vein. There is also a possibility of aspiration pneumonia, but this problem is largely limited to emergency procedures during active bleeding. Perforation and bleeding are very rare complications but may be serious and require hospitalization, blood transfusion, or surgery. There is potential for bruising or soreness in the mouth. In rare instances, teeth may be dislodged or damaged.

If procedural sedation will be used during this procedure, I understand that this sedation has risks. My physician has discussed the use of procedural sedation. The risks include but are not limited to slower breathing and low blood pressure that may require treatment.

I understand that a potential risk or complication of the procedure is the loss of blood. I understand that I may require blood products during the procedure or in the post-procedure period. If I refuse blood products, I will complete a separate release for blood-free treatment form.

I understand that one or more healthcare industry professionals (technical representatives for medical equipment and device companies) or observers may be present during this procedure for advisory or observational purposes only.

The hospital may photograph, videotape, or record my procedure/surgery for educational, research, quality and other healthcare operations purposes. Any information used for these purposes will not identify me.

I understand that blood or other samples removed during this procedure may later be disposed of by Massachusetts General Hospital. These materials also may be used by Massachusetts General Hospital, its partners, or affiliates for research, education and other activities that support Massachusetts General Hospital's mission.

A team of medical professionals will work together to perform my procedure/surgery. The role and involvement of the senior attending in my procedure has been discussed with me, including that he/she may join the procedure after the opening of the surgical site or may leave during the closing of the surgical site, and may need to step away during non-critical portions of the procedure. The roles of additional practitioners involved in the procedure, indicated below, have also been explained to me. I understand that other medical professionals may be involved in the procedure who are not listed below. The name of those practitioners will be shared with me after the procedure.

Role of Practitioner (check all that apply)		Name of Practitioner if known
	Fellow.	
	Resident. Specify Year:	
	Physician Assistant	
	Advanced Practice Nurse	
	Other, please specify:	
	Other, please specify:	

I have had a chance to ask questions about the risks, benefits, side effects, likelihood of achieving the goals of this procedure, and other approaches. All my questions were answered to my satisfaction and I give permission to have the procedure.

AM PM

Patient/Surrogate Decision Maker Signature | Printed Name if not Patient | Date Time

AM PM

Practitioner Obtaining Consent Signature | Printed Name | Date Time

Attending Physician/Primary Practitioner Attestation (not required if individual obtained original consent)
I attest that I discussed all relevant aspects of this procedure/surgery, including the indications, risks, and benefits, as compared with alternative approaches with the patient or surrogate decision maker, answered their questions, and provided information regarding other medical professionals who will be present during the surgery.

AM PM

Attending Signature | Printed Name | Date Time

If interpreter was used please complete name or number of interpreter: ______________________________

Telephone Consent
Date: __________________ Time: _______________ AM PM
Reason for Telephone Consent:____
Surrogate Decision Maker Name:____
Consent Received by:____
Consent Witnessed by:____