SOUTH SUBURBAN GASTROENTEROLOGY, PC
WEYMOUTH ENDOSCOPY, LLC

BERNARD F. SMITH, M.D. ~ JOHN P. VERMEULEN, M.D.
FERNANDO MARTINEZ, M.D. ~ CLAYLAND F. COX, M.D.
GREGORY M. BOLDUC, M.D. ~ BRADFORD C. SAMPSON, M.D.

1085 MAIN STREET ~ SOUTH WEYMOUTH, MA 02190
TEL: 781-331-2922 FAX: 781-335-5702
WEB SITE: WWW.SSUBGASTRO.COM

Dear Patient,

Thank you for choosing South Suburban Gastroenterology/ Weymouth Endoscopy for your procedure. Enclosed are the forms required in order to schedule your procedure. Please complete them and return them to the above address. Once we receive your completed forms we will schedule your procedure.

Please review the instructions at least one week prior to your procedure. You may purchase your prep at your local pharmacy.

If you have any questions please call us at 781-331-2922 or visit our web site at www.ssubgastro.com. We look forward to providing you with the highest quality of care.

Sincerely,

The Physicians of South Suburban Gastroenterology

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NEW PATIENT INFORMATION

NAME:________________________________ DATE OF BIRTH:__________________

STREET:_______________________________SOC. SEC. # _______________________

CITY:______________________ STATE:______ZIP:___________________________

MAIDEN NAME:______________________ MARITAL STATUS: M__S__D__W__

SPOUSES NAME:____________________ EMPLOYER:_______________________

HOME TEL:_____________CELL TEL:________________WORK TEL:___________
Please check all that apply:
□ It is OK to leave results from labs, tests and biopsies on my answering machine at my home/cell phone.

□ You can share results of labs, imaging tests, and biopsies with the following people:
____

ALLERGIES: ____

PRIMARY CARE MD:___________________ REFERRING MD:_________________

PRIMARY INSURANCE:___________________CERTIFICATE #:________________

SUBSCRIBER:______________ DOB:______________EMPLOYER:______________

SECONDARY INSURANCE:___________________CERTIFICATE#:_____________

I hereby authorize South Suburban Gastroenterology and/or Weymouth Endoscopy to furnish information to insurance carriers concerning my illness and treatment; and I hereby assign to the physicians all payments for medical services rendered to my dependents and/or myself. I understand that I am responsible for any amount not covered by insurance.

_____________________________ _____________________________

SIGNATURE DATE

SOUTH SUBURBAN GASTROENTEROLOGY
WEYMOUTH ENDOSCOPY, LLC

REVIEW OF SYSTEMS

Please answer all questions below
This will become a part of your medical record

Your Name:_______________________________

Constitutional

Recent Weight Change	___NO	___YES
Fever	___NO	___YES
Fatigue	___NO	___YES

Eyes

Blurred Vision	___NO	___YES
Glaucoma	___NO	___YES

Ears/Nose/Mouth/Throat

Hearing Loss	___NO	___YES
Ringing in Ears	___NO	___YES
Mouth Sores	___NO	___YES

Cardiovascular

Chest Pain	___NO	___YES
Shortness of Breath	___NO	___YES
Swelling of Ankles	___NO	___YES

Respiratory

Chronic Cough	___NO	___YES
Spitting up Blood	___NO	___YES
Wheezing	___NO	___YES

Genitourinary

Burning with Urination	___NO	___YES
Blood in Urine	___NO	___YES

Musculoskeletal

Joint Pain or Swelling	___NO	___YES
Back Pain	___NO	___YES
Muscle Pain	___NO	___YES

Skin

Rash	___NO	___YES
Itching	___NO	___YES

Gastrointestinal

Poor Appetite	___NO	___YES
Difficulty in Swallowing	___NO	___YES
Heartburn	___NO	___YES
Nausea or Vomiting	___NO	___YES
Bloating	___NO	___YES
Belching	___NO	___YES
Regurgitation	___NO	___YES
Constipation	___NO	___YES
Diarrhea	___NO	___YES
Abdominal Pain	___NO	___YES
Recent Change in Bowel Habits	___NO	___YES
Rectal Bleeding	___NO	___YES
Black, Tarry Stools	___NO	___YES

Neurological

Headaches	___NO	___YES
Seizures	___NO	___YES
Numbness	___NO	___YES
Strokes	___NO	___YES

Psychiatric

Memory Loss or Confusion	___NO	___YES
Depression	___NO	___YES

Endocrine

Heat or Cold Intolerance	___NO	___YES
Excessive Thirst or Urination	___NO	___YES

Hematological

Bleeding or Bruising Tendency	___NO	___YES
Anemia	___NO	___YES
Past transfusion	___NO	___YES

Are you Pregnant?	___NO	___YES

COMMENTS/CONCERNS:

____

____

____

____

PATIENT HISTORY FORM Date of Birth__________________

Date: _____________________ Name:____

Race: Asian White African American Unreported Ethnicity: Hispanic/latino Non Hispanic/latino Unreported

Language:_________________________ Height:___________ Weight:________________

Primary Care Physician: __________________Pharmacy: ________________ Location:__________________

Reason for today's visit:____

LIST **ALL** PRIOR SURGERIES AND DATES:____

____

List any Past or Present Medical Illnesses (please circle):

Hypertension Heart Attack Angina Arrhythmia Congestive Heart Failure Heart Murmur Elevated Cholesterol
Diabetes Anemia Arthritis Blood Clot in Leg or Lung Seizure Stroke Hepatitis Tuberculosis Cancer
Asthma Bronchitis Emphysema Rheumatic Fever Thyroid Disease Peptic Ulcer Hiatal Hernia Ulcerative Colitis
Crohn's Disease Irritable Bowel Syndrome Other: ____

Do you have any allergies to Medication? _______________

____

____

List Names of Medications you are taking: (include aspirin And herbal meds)

____

____

____

____

____

Have you ever smoked? No Yes

If currently smoking, how many packs per day? __

If not currently smoking, quit date: ____________

____

Do you drink alcohol? None Occasional Daily

Recreational drug use? No Yes

Marital Status: Single Married Divorced Widowed

Age: _________ Female Male # Children __________

Do you work? No Yes Type of Work:______________

If retired, Occupation Before Retirement:______________

Any Family History of liver disease, celiac disease, Crohn's, ulcerative colitis, other cancer ?_______________________________

Colon Polyps: No Yes Whom:_____________________ # of Siblings(Alive or Deceased) ___________________

Colon Cancer: No Yes Whom:_____________________

Other Significant Disease(s):____

Have you ever had any problems with anesthesia or sedation? ____

To Be Completed by Gastroenterologist on day of exam:

HPI:____

____

____

____

____

____

Physical Examination: BP______ Hgt______Wgt______	**Yes**	**No**	**Comments**
1. Constitutional: Well nourished/well developed:			
2. Skin: Skin free of rashes, purpura, petechiae, stigmata:			
3. Eyes: Lids and Conjunctivae normal:			
4. Ears/Nose/Mouth/Throat: Is the oral mucosa pink/moist			
5. Hematologic/Lymphatic/Immunologic: Nodes in neck nl:			
6. Respiratory: Lungs clear to auscultation:			
7. Cardiovascular: Heart rate regular & no murmur:			
8. Gastrointestinal: Soft, nl tympany, active bs, no hsm,			
no masses, no tenderness			
9. Musculoskeletal: No clubbing, deformities, edema of extremities			
10. Rectal: Hem occult negative:			
11. Neurologic: Intact			
12. Psychiatric: Alert, oriented to time/person/place			

Reviewed By____ Date:______________________________

ASA: ___________

I have reassessed the patient and find no changes to the above

Signed: ____ Date: ______________________________

WEYMOUTH ENDOSCOPY, LLC
PATIENT MEDICATION HISTORY FORM

Name:______________________________Date of Birth:_________________________________

Date:_____________________________
Please Complete the Medication and allergy section of this form. Please bring it with you on the date of your procedure

ALLERGIES and REACTIONS:

____

____

____

Name of Medication/Vitamin/OTC	Dose	How often taken	Last dose taken
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Physician Documentation:

Any changes to medication after procedure: **No** **Yes** ___________________________________\

Resume aspirin, ibuprofen, aleve, Excedrin or any aspirin product in ___________ days

New medication added today: **No** **Yes** ____

MD signature:___________________________________ Date:________________________________

Nursing Documentation:

Today you had the following procedure: ____Colonoscopy ____Gastroscopy ____Flexible Sigmoidoscopy

You were given the following medications: _____Versed_____Fentanyl_____Demerol
other:________________Endoclip was used today No Yes - If yes and you require an MRI in the future please notify the Radiologist

Nurse Initial:_________________ Date:____________________________

WEYMOUTH ENDOSCOPY, LLC.

CONSENT FOR COLONOSCOPY

My physician has recommended a Colonoscopy to evaluate the following condition:

____

1. **CONDITION**

My physician has explained to me the technique of Colonoscopy, the risks and benefits of Colonoscopy, additional procedures, which may be performed during Colonoscopy and the way in which I will be sedated for my Colonoscopy. I have had an opportunity to ask any questions, discuss alternative therapies, risk and benefits and I have received appropriate responses to these questions.

2. **PROCEDURE: DESCRIPTION OF COLONOSCOPY**

Colonoscopy is an examination of the Colon, using a flexible scope, which will be inserted into the rectum and advanced under visual guidance throughout the entire length of the colon to its junction with the small intestine into the cecum and sometimes into the small intestine. During Colonoscopy, an image of the inside lining of the colon is portrayed on a video monitor and reviewed by my physician. This technique allows the physician a detailed examination of the lining of the bowel where pathology is most likely to occur. This technique has the ability to diagnose most of the common diseases of the colon and to exclude those diagnoses, which are of the greatest concern. Any tissue removed during Colonoscopy will be sent to a pathology laboratory where a Pathologist will review it. A colonoscopy is an imperfect exam and there is a small but real possibility that significant pathology including polyps and small cancers may be missed.

ADDITIONAL PROCEDURES:

Additional procedures are commonly performed during Colonoscopy, which include biopsies of the lining of the large bowel, Polypectomy, which is the removal of polyps and cautery of abnormal blood vessels. Sometimes dilation of stricture or tattoo of lesion site is required. These procedures are performed routinely in Colonoscopy if the appropriate pathology is identified during that examination.

3. **RISKS AND BENEFITS**

RISKS OF COLONOSCOPY:

The risks of Colonoscopy are rare, but may be serious and life threatening. These risks include perforation of the colon by the Colonoscope, which usually requires surgical repair. It is possible that a Colostomy may need to be performed during the repair of a perforation. Additional risks include bleeding, which is most likely to occur after removal of a polyp. Bleeding is usually self-limited, but may be serious and can possibly require transfusions and/or surgery to control. Infections, leakage of air from the bowel into the abdominal cavity are also possible complications. Additional risks associated with any invasive procedure, but not specifically associated with Colonoscopy include unanticipated bleeding, development of blood clots, tissue damage, respiratory problems, infections, and cardiovascular or pulmonary complications. **I understand that do not resuscitate directives will not be honored at this facility.**

SEDATION:

During Colonoscopy I will receive intravenous medicine for sedation. This technique may use several different medications alone or in combination, which result in the induction of a sleep like state, during which memory is often impaired. The degree of sedation varies from person to person and it is conceivable that some pain may be felt during the procedure or some discomfort remembered after the procedure. My physician is limited in the amount of medicine that can be administered by safety factors and changes in my vital signs. Complications from sedation include: Inadequate Respiration, which may require respiratory assistance or reversal of the sedative, low blood pressure, erratic or slow pulse rate, all of which may require administration of additional medications.

4. **ACKNOWLEDGEMENT**

I understand the need for Colonoscopy. I understand the potential benefit of the procedure and the potential risks associated with it.

5. **CONSENT**

I give my consent to have the procedure performed by Dr. ________________________.

____________________________ ____________________________

Patient/Legal Representative Witness

____________________________MD ____________________________

Physician Signature Date

SUBJECT: PATIENT'S BILL OF RIGHTS

The purpose of this policy is to establish guidelines for Weymouth Endoscopy Center's patient's rights. Copies of the Bill of Rights shall be displayed prominently in the waiting area.

POLICY

1. A Patient has the right to respectful care given by competent personnel.
2. A Patient has the right, upon request, to be given the name of his attending practitioners, the names of all other practitioners directly participating in his care, and the names and functions of other health care persons having direct contact with the patient.
3. A Patient has the right to consideration of privacy concerning his own medical care program. Case discussion, consultation, examination, treatment, and medical records are considered confidential and shall be handled discreetly.
4. A Patient has the right to confidential disclosures and records of his medical care except as otherwise provided by law or third party contractual arrangement.
5. A Patient has the right to participate in decisions involving his health care except when such participation is contraindicated for medical reasons.

6. A Patient has the right to know what Weymouth Endoscopy Center's rules and regulations apply to his conduct as a patient.

7. The Patient has the right to expect emergency procedures to be implemented without unnecessary delay.

8. The Patient has the right to good quality care and high professional standards that are continually maintained and reviewed.

9. The Patient has the right to full information, in layman's terms, concerning diagnosis, evaluation, treatment and prognosis, including information about alternative treatments and possible complications. When it is not medically advisable to give the information to the patient, the information shall be given on his behalf to the person designated by the patient or to a legally authorized person.

10. Except for emergencies, the practitioner shall obtain the necessary informed consent prior to the start of a procedure.

11. If the patient is unable to give consent, a legally authorized person has the right to be advised when a practitioner is considering the patient as a part of a medical care research program or donor program. The patient or responsible person shall give informed consent prior to participation in the program. The patient or responsible person may refuse to continue in a program to which he has previously given informed consent.

12. A Patient has the right to refuse drugs or procedures, to the extent permitted by status. *A practitioner shall inform the patient of the medical consequences of the patient's* refusal of drugs or procedures.

13. A Patient has the right to medical and nursing services without discrimination based upon age, race, color, religion, sex, national origin, handicap, disability, or source of payment.

14. The Patient who does not speak English shall have access, where possible, to an interpreter.

15. Weymouth Endoscopy Center shall provide the patient, or patient designees, upon request, access to the information contained in his medical records, unless the attending practitioner for medical reasons specifically restricts access.

16. The Patient has the right to expect good management techniques to be implemented within Weymouth Endoscopy Center. These techniques shall make effective use of time for the patient and avoid personal discomfort of the patient.

17. When an emergency occurs and a patient is transferred to another facility, the responsible person shall be notified. The institution to which the patient is to be transferred shall be notified prior to the patient's transfer.

18. The Patient has the right to examine and receive a detailed explanation of his bill.

19. A Patient has the right to expect that Weymouth Endoscopy Center will provide information for continuing health care requirements following discharge and the means for meeting them.

20. The Patient is informed of his/her right to change physician, if another qualified physician is available.

21. A Patient has the right to be informed of his rights at the time of admission.

22.The patient is informed that the Endoscopy Center is owned by the physicians of South Suburban Gastroenterology, including: Bernard Smith, John Vermeulen, James Moore, Clayland Cox, Gregory Bolduc and Bradford Sampson, and each patient has the freedom of choice in selection of facility or physician

23. The patient has the right to view credentialing policies of the Center. No specific information regarding credentialing of individual physicians will be provided.

24. The patient has the right to have a Massachusetts Health Care Proxy on file.

25. The patient has the right to exercise his or her rights without being subjectedto discrimination or reprisal.

SUBJECT: PATIENT CONDUCT AND RESPONSIBILITIES

The purpose of this policy is to outline Weymouth Endoscopy Center's patient responsibilities in regards to their appointment, cooperation, and information provided for insurance claims.

POLICY

1. Please keep appointments or telephone Weymouth Endoscopy Center when you cannot keep a scheduled appointment. Bring with you information about past illnesses, hospitalizations, medications, and other matters relating to your health. Ask questions immediately if you feel you cannot follow the instruction.

2. While practicing in Weymouth Endoscopy Center, your doctor is obligated to exercise good medical judgment in order to help you. It is your responsibility to cooperate in the treatment program that your doctor specifies.

3. You are expected to be considerate of other patients, their family members, and the property of other persons.

4. Authorized members of your family are expected to be available to other personnel for review of your treatment in the event that you are unable to communicate with the physicians or nurses.

5. You have a responsibility to provide information necessary for insurance processing of your bills, to be prompt about payment of office/center bills, and to ask any questions you may have concerning your bills. Our billing specialist is available to assist you.

6. It is your right to have an advanced directive; however, if you have a procedure done in this facility and have signed a consent form, we will provide emergency services if necessary.

Communication between you and our team is an important element in good health care. If you are concerned about or displeased with any aspect of your care, we ask that you first discuss the problem with your nurse or physician. If your concern is not alleviated, please contact Weymouth Endoscopy Center's Nurse Manager. All patients have the right to file a complaint or grievance without fear or reprisals.

Suggestions or comments you would like to make following discharge are most appreciated. We are continuously trying to improve the care that we provide. Please forward your communication to:

Mary Phillips, RN
Weymouth Endoscopy Center
1085 Main St
South Weymouth, MA 02190

All communication forwarded to the Nurse Manager will be investigated immediately

The official website for the Office of the Medicare Beneficiary Ombudsman is:
http://www.medicare.gov/navigation/help-and-support/ombudsman.aspx?Nav=Top

Patient complaints may be filed to the state by writing a letter to:
Division of Health Care Quality
Complaint Unit
99 Chauncy Street
Boston, MA 02111
Hotline: 1-800-462-5540

SOUTH SUBURBAN GASTROENTEROLOGY/WEYMOUTH ENDOSCOPY
NOTICE OF PRIVACY PRACTICES
EFFECTIVE: SEPTEMBER 2013

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operation.

- Treatment means providing, coordination, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a surgeon.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be patient satisfaction surveys.
- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-indentified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person indentified by you. We are,

however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI Is intentionally or unintentionally disclosed.

If you have paid for services “out of pocket”, in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of September 9, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing.

Magnesium Citrate Colonoscopy Instructions

Your Colonoscopy has been schedules for, day and date_____________time___

Please arrive ½ hour prior to your appointment

Purchase 3 bottles of Magnesium Citrate (except red) at any pharmacy. You do not need a prescription. Magnesium Citrate is a safe and effective method to cleanse the colon for most patients. If you have any kidney problems, this prep should not be used for you. An excellent prep means excellent visualization of the colon and a more comfortable exam.

Please read the instructions below carefully and discuss any questions that you have prior to your exam. We may have to reschedule your colonoscopy if your prep is not adequate.

1) **ONE WEEK PRIOR:** After checking with your physician do not take any iron pills or medicine that can cause bleeding (ie: Aspirin,Percodan,Alka-Seltzer). Also stop any anti-inflammatory type drugs (ie: Ibuprofen,Motrin,Naproxen,
Indocin,Diclofenac, Voltaren—unless approved by your gastroenterologist) ***if you take coumadin (warfarin), Plavix, Plentyl, Aggrenox, Trental…you should discontinue taking it prior to your procedure unless specified by your PCP.*
2) **FIVE DAYS PRIOR:** Restricted residue diet—no nuts, seeds, popcorn, corn.
3) **THE DAY BEFORE** you are to start a <u>CLEAR LIQUID DIET,</u> no solid food! This should start at breakfast. Samples of acceptable foods include:
   - Black tea/coffee (no milk or cream)
   - Clear broth/bouillon
   - Italian ice or popsicles
   - Gatorade, apple or cranberry juice, any clear or carbonated beverage (Soft drinks, Gatorade, flavored water, etc)
   - Jello
     No solid food or juice with pulp!! No Milk products!! Food dyes (specifically RED) should be avoided

   Beginning at 4:00 pm drink one 10oz bottle of Magnesium Citrate. At 6:00 pm drink another 10 oz bottle of Magnesium Citrate. To prevent dehydration, drink plenty of clear liquids all evening (at least 64 oz). Stay close to toilet facilities at this time! If you develop irritation from frequent bowel movements, use a soothing cream such as Vaseline, A+D ointment, or balmex.
4) **DAY OF EXAM:** 3-4 hours prior to your exam, drink another bottle of Magnesium Citrate. Please continue to drink fluids up to 3 hours prior to exam. Any prescribed meds may be taken with a sip of water. Please bring with you any paperwork that you've filled out for this appointment.
   If you are an insulin dependant diabetic, please check with your physician regarding dosages!!!!**
5) **<u>You will be given medication that will sedate you during the procedure. Because of this, you will not be allowed to drive yourself home or take public transportation. You must have somebody accompany you home following the procedure!!!</u>**

Frequently Asked Questions and Answers

Q: What is a Colonoscopy?

A: A colonoscopy is an examination of the colon using a flexible scope. This technique has the ability to diagnose most of the common diseases of the colon and removal of small growths or polyps. A colonoscopy is well-tolerated and rarely causes much pain. Air is used to inflate your colon so that the physician can visualize the inner walls, you sense this as a gas cramp and this is why sedation is used.

Q: What type of Sedation is used?

A: A Moderate (Conscious) Sedation is used. Moderate sedation is the use of medications to depress the level of consciousness in a patient while allowing the patient to breathe independently and respond appropriately to verbal commands and/or gently stimulation. Most patients sleep through the exam and wake just as the exam is finishing.

Q: What are Polyps?

A: Polyps are abnormal growths in the colon lining that are usually benign. They vary in size from a tiny dot (the size of a freckle) to several inches. There are 2 main types of polyps: adenomas (pre-cancerous) and hyperplastic (benign, non-cancerous). Your doctor can't always differentiate between the 2, benign vs precancerous, by its outer appearance, so he/she sends the removed polyps to a pathologist for analysis. Because cancer begins as a polyp, removing them is an important means of preventing colon cancer.

Q: What happens after a Colonoscopy?

A: The physician will speak with you after the exam and review preliminary results. Biopsies may take up to one week to result from pathology. Sedation will be used during the procedure so someone must drive you home and stay with you. Even if you feel alert after the procedure, your judgment and reflexes will be impaired for the rest of the day. You might have some cramping or bloating because of the air introduced into the colon during the exam. This should disappear quickly when you pass gas. You should be able to resume a normal diet after the exam!!!