

IF YOU ARE ON ANY WEIGHT LOSS MEDICATION,
PLEASE LET US KNOW, AS IT NEEDS TO BE HELD AT
LEAST 1 WEEK PRIOR.

DATE :

ARRIVAL TIME :

PROCEDURE TIME :

NOTHING TO EAT AFTER MIDNIGHT.

STOP ALL FLUIDS 4 HOURS PRIOR TO PROCEDURE TIME.

PLEASE READ INCLUDED INSTRUCTIONS THOROUGHLY
PRIOR TO PROCEDURE DAY.

PLEASE COMPLETE AND BRING THE ATTACHED
MEDICATION FORM THE DAY OF YOUR PROCEDURE.

North Shore Digestive Medicine, P.C.
Farzad Forohar, M.D.
50 Route 111, Suite 302
Smithtown, NY 11787
Phone: 631-724-5300/Fax: 631-724-5400

Mr/Ms _____ is scheduled for an **EGD**
on _____ @ _____.

(PLEASE ARRIVE 1 HOUR BEFORE PROCEDURE TIME)

ARRIVAL TIME: _____

IMPORTANT REMINDERS:

DO NOT EAT ANYTHING AFTER MIDNIGHT THE NIGHT PRIOR TO YOUR PROCEDURE.
You may continue to drink ONLY WATER up to 4 hours prior to your procedure time. Do not have ANYTHING within 4 hours of your procedure!

YOU MUST HAVE SOMEONE DRIVE YOU HOME FROM YOUR PROCEDURE. YOU MAY NOT DRIVE FOR 24 HOURS AFTER YOUR PROCEDURE. When you arrive for your procedure, we will take the name and phone number of the person picking you up and call them to confirm. When they pick you up, they must come up to the office and sign you out. Your procedure will be canceled if these arrangements are not made.

If you take **Coumadin, Plavix, Lovenox or any other anticoagulant (blood thinning) medication**, you will need approval from your primary care physician, hematologist, or cardiologist before stopping the medication prior to the procedure. If you are taking **Ozempic, Mounjaro, or any other semaglutide medication**, this must be stopped at least 1 week prior to your procedure. If you are taking any of these medications for diabetes, please get instructions on stopping the medication from the prescribing physician. **Keep taking blood pressure medication and other medications unless told otherwise.** If you are **diabetic** and receive insulin or oral medication, you should have received special instructions on what to do with your medication the day before and the morning of the procedure.

Please do not hesitate to contact our office if you have any questions or need additional information.

PLEASE COMPLETE THE ATTACHED MEDICATION FORM AND BRING IT BACK THE DAY OF YOUR PROCEDURE FILLED OUT AND SIGNED BY YOU.

THANK YOU!

PRE-PROCEDURE MEDICATION RECONCILIATION / VERIFICATION FORM

Patient Name: _____ Patient DOB: _____

Procedure Date: _____ Allergies: _____

Medications (Please include any routine over the counter medications)	Dose	Route	Frequency	Medication Held Prior to Procedure? (Yes or No)	Re-Start (C) or Hold (H) at Discharge?
New Medication (Started after Procedure)	Dose	Route	Frequency		

I have reviewed this list with the patient.

Physician Signature: _____ Date/Time: _____

Patient Signature: _____ Date/Time: _____

Please bring back day of procedure

CANCELLATION POLICY FOR ALL PROCEDURES

Starting five days before your procedure you will receive an email to confirm your appointment, as well as a text message, and a phone call. It is **REQUIRED** that you confirm your appointment by one of these methods **48 hours before** your procedure, or your **procedure will be cancelled**.

In addition, if you do not show up to your procedure or cancel the morning of, you will be billed a **fee of \$100**.

Thank you!