ATLANTA ENDOSCOPY CENTER, LTD.
2665 N. DECATUR RD., SUITE 545, DECATUR, GA 30033

PATIENT:_____MR#_____DATE_____MD_____

You have received sedation for your procedure today. These medications will remain in your system for some time. You may have dizziness and feel off balance. Your reflexes, fine muscle control and judgment may be altered. These changes may be difficult for you to recognize; thus, for your own safety, we have several strict instructions for you to follow for the day of your procedure.

THE SIX D'S FOR THE DAY OF YOUR PROCEDURE

- **DO NOT DRIVE** any vehicle
- **DO NOT** use potentially **DANGEROUS** equipment or appliance (examples are lawnmowers, power tools, stove/burners, etc.)
- Watch out for **DIZZINESS**. Move slowly and take your time.
- **DO NOT** make important **DECISIONS** as you may change your mind after the medications have worn off.
- **DO NOT DRINK** alcoholic beverages, since the medications you have received may interact with alcohol and be dangerous.
- **DISCUSS** any questions or concerns with your Doctor or their staff.

AFTER YOUR PROCEDURE

1. _____ Return to your regular diet.

2. _____ Drink only liquids or soft foods, until the following morning, then return to your regular diet.

3. _____ Other diet as instructed:_____

4. _____ You may have some mild abdominal pain, cramping and nausea after the procedure. **If these worsen, or if you have fever, chills, abdominal distention, rectal bleeding, then notify your doctor at 404-296-1986**

5. _____ Your IV site may be somewhat tender for 1 to 2 days. You may place warm compresses on the site. **If redness, swelling, or fever occurs then call your doctor.**

6. _____ Resume your previous medications unless notified otherwise._____

7. _____ You may return to work the following day unless notified otherwise.

8. _____ Call the **office @404-296-1986** _____ to discuss the results your procedure or biopsy.
   _____ Please have a pharmacy number available.

9. _____ Schedule a follow up visit with your doctor in _____ days/weeks/months/years.

Other_____

_____

_____

_____

I hereby acknowledge the receipt of and understand the above instructions. I also understand that it is my responsibility to report any abnormal occurrences and to arrange follow up care, as noted above.

PATIENT OR ESCORT SIGNATURE_____**MD**_____