TORONTO IMMUNE & DIGESTIVE HEALTH INSTITUTE

ENDOSCOPY PACKAGE

PATIENT NAME: ____________________

PROCEDURE DATE: ___________________ at __________________ with ___________________________

Please arrive to the Toronto Immune and Digestive Health Institute 1 hour prior to your procedure time
700 Lawrence Ave. W., 3rd floor, Suite 360, Toronto, ON, M6A 3B4 (T: 647-812-2113)
Enter through the East Tower Entrance, located between Booster Juice and the Foot Institute

Arrange for a pick-up **2 hours after your procedure start time.**
If you do not have an adult accompany you home, your procedure will be cancelled.

The Endoscopy Package includes the following documents:*

1. General Information (1 page)
2. Pre-Anesthesia Questionnaire (3 pages)

*Contact the office immediately if you are missing any of the documents listed above.

Please read **ALL** the documents enclosed within the Endoscopy Package carefully. Failure to follow the instructions may result in the cancellation of your procedure.

If you have any questions or require further information, please contact the clinic and one our staff members will be happy to assist you.

Toronto Immune and Digestive Health Institute
700 Lawrence Avenue West
3rd floor, Suite 360,
Toronto, ON M6A 3B4
Phone: 647-812-2113
Email: reception@tidhi.ca

CANCELLATIONS WITH LESS THAN 5 BUSINESS DAY'S NOTICE WILL RESULT IN A $200 FEE NOT COVERED BY OHIP

TORONTO
IMMUNE &
DIGESTIVE HEALTH
INSTITUTE

GENERAL INFORMATION

IMPORTANT INFORMATION

- If you have sleep apnea plan to bring your CPAP machine to the procedure
- Continue any blood pressure medication as usual
- If you missed any of the steps on the previous page, PLEASE STILL COME IN FOR THE PROCEDURE
- DO NOT BRING ANY VALUABLES JEWELLERY OR WEAR MAKE UP
- You will be sedated during the procedure. Therefore, **YOU MUST BE ACCOMPANIED BY SOMEONE WHEN YOU LEAVE.** If you do have someone to accompany you, your procedure will be cancelled.

WHEN YOU ARRIVE

- The Toronto Immune and Digestive Health Institute is located in the Lawrence-Allen Centre at (700 Lawrence Avenue West). There is free, unlimited parking and adjacent TTC/Subway access (Lawrence West Station).
- Please enter through the East Tower entrance, which is accessible from the parking lot on the south side of the mall facing Lawrence Avenue. The East Tower entrance can be found between Booster Juice and the Foot Institute.
- Once inside, take the elevators up to the 3rd floor – Suite 360.
- Unfortunately due to COVID restrictions, your escort cannot accompany you inside the clinic. Your escort can visit the retail shops at the Lawrence-Allen Centre, which provides immediate access to food, shopping and other amenities. Your escort will be informed when you are ready to be picked up.

TORONTO IMMUNE & DIGESTIVE HEALTH INSTITUTE

700 LAWRENCE AVE W, SUITE 360
TORONTO, ONTARIO M6A 3B4

T: 647 812 2113
F: 647 812 2114

PRE-ANESTHESIA QUESTIONNAIRE

Please fax completed form to 647-812-2114 at least 14 days prior to the scheduled procedure.

*****Please note if you are on Ozempic or Wegovy to contact the clinic ASAP as your procedure may be cancelled*****

Date of Procedure (MM/DD/YY)**:**

Name *(Last, First, M.I.):*		**DOB** (MM/DD/YY)**:**
OHIP #:	**Version Code:**	
Emergency Contact Name:	**Relationship:**	**Phone:**

MEDICAL HISTORY

Cardiac Health		
Angina	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
Atrial Fibrillation	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No
Cardiac Valve Disorders	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Stent/Angioplasty	☐ Yes	☐ No
Other:		

Blood Health		
Anemia	☐ Yes	☐ No
Sickle Cell Trait	☐ Yes	☐ No
Sickle Cell Anemia	☐ Yes	☐ No
Bleeding Disorder	☐ Yes	☐ No
Deep Vein Thrombosis or Pulmonary Embolism	☐ Yes	☐ No
Aneurysm	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Other:		

Respiratory Health		
Asthma	☐ Yes	☐ No
COPD	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Sleep Apnea ☐ CPAP	☐ Yes	☐ No
Other:		

Endocrine and Metabolic Health		
Diabetes ☐ Type I ☐ Type II	☐ Yes	☐ No
Thyroid Disease *name:*	☐ Yes	☐ No
Other:		

Gastrointestinal Health		
Heartburn or GERD	☐ Yes	☐ No
Hiatus Hernia	☐ Yes	☐ No
Liver Disease *name:*	☐ Yes	☐ No
Inflammatory Bowel Disease	☐ Yes	☐ No
Difficulty Eating or Swallowing	☐ Yes	☐ No
Nausea or Vomiting	☐ Yes	☐ No
Other:		

Neuro and Musculoskeletal Health		
Dementia	☐ Yes	☐ No
Alzheimer's disease	☐ Yes	☐ No
Migraine	☐ Yes	☐ No
Vertigo	☐ Yes	☐ No
Neuropathy	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No
Spinal Stenosis	☐ Yes	☐ No
Osteoarthritis	☐ Yes	☐ No
Rheumatoid Arthritis	☐ Yes	☐ No
Epilepsy or Seizure Disorder	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No
Parkinson's disease	☐ Yes	☐ No
Other:		

Kidney and Bladder Health		
Kidney Disease *name:*	☐ Yes	☐ No
If yes, are you on dialysis?	☐ Yes	☐ No
Other:		

Other Significant Conditions:

CURRENT MEDICATIONS

☐ No prescription medications	☐ No over-the-counter medications, supplements, vitamins, or probiotics

Medications, supplements, vitamins or probiotics:	Dose:	Frequency:	Indication:

ALLERGIES

Medication or Substance *(e.g. latex, food, etc.)*:	Type of Reaction:

ANESTHETIC HISTORY

Have you ever had general anesthesia?	☐ Yes	☐ No
If yes, please describe:		
Have you ever had regional anesthesia? *(e.g. nerve block, epidural, spinal, etc.)*	☐ Yes	☐ No
If yes, please describe:		
Have you had any reactions to anesthesia in the past?	☐ Yes	☐ No *If yes, check/describe below.*
☐ Malignant Hyperthermia	☐ Pseudocholinesterase	☐ Confusion after surgery
☐ Other Reaction:		
Has a family member ever had a serious reaction to anesthesia?	☐ Yes	☐ No
If yes, please describe:		

ADDITIONAL SCREENING QUESTIONS

Do you bruise easily?	☐ Yes	☐ No	
Do you use home oxygen?	☐ Yes	☐ No	
Do you have loose teeth or dentures?	☐ Yes	☐ No	
Do you have any severe visual or hearing impairments?	☐ Yes	☐ No	
Do you drink alcohol?	☐ Yes	☐ No	If yes, number of drinks/week:
Do you smoke?	☐ Yes	☐ No	If yes, type + amount/week:
Do you use recreational drugs?	☐ Yes	☐ No	If yes, type + amount/week:
If female, are you currently pregnant?	☐ Yes	☐ No	☐ N/A
Please write down your height and weight and the unit of measurement:	Height: (ft/cm)	Weight: (lbs/kg)	

______________________________ **Patient Signature**

______________________________ **Date** *(MM/DD/YY):*