AMBULATORY ENDOSCOPY CENTER OF MARYLAND
7350 Van Dusen Road, Suite 230
Laurel, MD 20707
(301) 498-5500

DISCHARGE INSTRUCTIONS

Name	Date	Acct. #

YOU ARE HAVING THE FOLLOWING PROCEDURE(S) PERFORMED TODAY:

☐ COLONOSCOPY ☐ UPPER ENDOSCOPY ☐ OTHER: _____

If biopsies were taken or polyps removed, avoid aspirin-like products (including Nuprin, Ibuprofen, Motrin, Advil) for one week after the procedure. You may take Tylenol (acetaminophen) for discomfort or headache.

I. Following sedation, your judgement, perception, and coordination are considered impaired for up to 24 hours after leaving the center. Therefore we recommend that you:

- Do not drive or operate appliances or machinery that require quick reaction time.
- DO NOT SIGN LEGAL DOCUMENTS OR BE INVOLVED IN WORK DECISIONS.
- Do not smoke or drink alcoholic beverages.
- Plan to spend a few hours resting before resuming your normal routine.

II. You may experience tenderness, swelling or pain at the site where the intravenous medication was given. You may apply a hot towel to the area.

PLEASE CALL YOUR PHYSICIAN IN THE EVENT THAT YOU EXPERIENCE ANY OF THE FOLLOWING:

FOR UPPER ENDOSCOPY

- DIFFICULTY SWALLOWING OR BREATHING
- NECK SWELLING
- EXCESSIVE PAIN
- NAUSEA OR VOMITING
- ABDOMINAL DISTENSION
- FEVER

Mild throat soreness may follow this procedure. Warm salt water gargling or lozenges may relieve your discomfort.

FOR COLONOSCOPY

- SEVERE ABDOMINAL DISTENSION AND/OR PAIN (some mild distension and/or cramping is normal after these procedures but should pass within an hour or two with passage of air.)
- RECTAL BLEEDING MORE THAN BLOOD STREAKING ON THE TOILET TISSUE
- NAUSEA OR VOMITING
- FEVER

Physician Instructions

I. Diet: ☐ Resume previous diet ☐ _____

II. Activity: ☐ Resume regular activity tomorrow

III. Medication Changes: ☐ None ☐ _____

IV. Disposition (follow up):

☐ In Laurel/Takoma Park/Ellicott City on _____.
(date / time)

☐ You will receive a letter informing you of your pathology results.

☐ Recall for procedure in _____ years.

☐ None needed at this time.

V. Other: _____ **Physicians Signature:** _____

I, the undersigned, have read and understand the above instructions.

Patient Signature: _____ Witness: _____ Time: _____

White - Patient Yellow - AEC