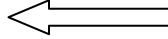
Greg S. Cohen, MD
GI Lab Address
259 East Erie Street, Lavin Family Pavilion  **go here for the procedure**
16th Floor Reception Area
Chicago, IL 60611 312-695-4452

Esophageal Manometry Test

This test of your esophagus is called an Esophageal Motility or Esophageal Manometry Test. **The procedure will be done in the GI Procedure suite on the 16th floor of the Lavin Family Pavilion, 259 E Erie St.** If you have questions please call 312-926-2425 Monday – Friday, 8:00 am – 4:00 pm. If you need to cancel, please call with at least 72 hours notice.

This test may help to find out why you are having pain or difficulty swallowing. The test measures the strength and coordination of the muscles in your esophagus, and the location and function of the Lower Esophageal Sphincter (LES). This sphincter is the barrier between your esophagus and stomach, which controls the reflux of stomach acids.

During this test a thin, flexible, soft catheter (small tube) is passed through your nose into your stomach, while you are given sips of water to swallow. The catheter is connected to a computer that shows the pressure in your esophagus. **The test takes about 30 minutes to complete.**

Prior to the test, the nurse will ask you questions about what medications you are taking and your medical history. Please complete the patient questionnaires which are attached to this packet and bring them with you to the GI lab on the day of your test. **Please do not have anything to eat or drink 6 hours prior to the test.** If you are on diabetes medication you will need to check with your physician to determine if you should take these the morning of the exam.

The test will take approximately 90 minutes from checking in to the end of the test. The procedure will be explained to you and questions that you have will be answered. Once the test results become available, your doctor will review the results and call to discuss them with you.

Northwestern Medicine®

GI LAB PATIENT QUESTIONNAIRE

Refer to Reminder below before completing this form. Thank you for choosing Northwestern Memorial Hospital for your GI Lab procedure. **Please fill out this form and bring it with you the day of the procedure.** Please answer each question. This allows us to provide you with the best possible care.
(Please print)

Patient Name ______________________ **Date of Birth** __________ **Date of Procedure** __________

Name of Primary Care Physician ______________________ **Fax Number** __________

Address ______________________ **Phone Number** __________

Procedure and Related Information: *** Procedure normally requires sedation**

- ☐ Flexible Sigmoidoscopy
- ☐ Colonoscopy*
- ☐ Upper Endoscopy (EGD)*
- ☐ Endoscopic Ultrasound/Fine Needle Aspiration*
- ☐ ERCP*
- ☐ Liver Biopsy*
- ☐ Esophageal/Rectal/Small Bowel Manometry
- ☐ 24-hour Ambulatory pH Study
- ☐ Other ______________________

Reason for visit? ______________________

Please list the date of your last colonoscopy __________ (Month) __________ (Year)

Please list the date of your last upper endoscopy (EGD) ______________________

When was the last time you ate solid food? Date __________ Time __________

When was the last time you drank liquid? Date __________ Time __________

If your test required a bowel preparation, what preparation did you take? __________

Did you complete the preparation? ☐ Yes ☐ No–how much did you complete? __________

On the day of your procedure, will you have any of the following: *(Please circle)* Dentures, Removable Bridgework, Glasses, Hearing Aide, Walker, Cane, Wheelchair, Prosthetics, Other __________

Family/Friends/Transportation:

Who will be waiting for you during the procedure and/or taking you home afterwards?

Name ______________________ Relationship __________

Daytime contact number(s) ______________________

Verified by Admitting Nurse ______________ Date __________ Time __________

Reminder: Per NMH Policy, after receiving any amount of sedation, you MUST have a responsible adult accompany you home after your procedure. You will not be discharged for any reason without an escort.

- If the admitting staff cannot verify your ride home, your procedure will be cancelled.
- You may not walk or take a cab/Uber/CTA home.
- You may not leave the GI Lab unaccompanied for any other appointments you have within NMH.

If your home is within the set service area of Superior Ambulance Company, you may make arrangements for them to take you home for an additional fee (contact Superior for pricing). If you would like to arrange this service, please call 312.926.5988 to make arrangements. Payment will be required at the time of service.

→ Complete both sides of form

Do you take?

YES	NO		YES	NO	
☐	☐	Sleeping or Anti-anxiety Medications, Sedatives	☐	☐	Prescribed Anticoagulants, Blood Thinners Last Dose Taken (Date ________________ Time ____________)
☐	☐	Aspirin or Non-steroidal Anti-inflammatory Drugs	☐	☐	Insulin or pills to control your blood sugar

Past/Present History:

YES	NO	
☐	☐	Are you currently experiencing pain? ________________ Is your pain chronic? ________________ Location ________________ Please rate your pain – 0 (no pain) to 10 (worst pain) ________________
☐	☐	Have you or has anyone in your family ever had reactions to the medications given to you during any procedures or surgery? ________________ Please describe ________________
☐	☐	Allergies (such as drug, food, latex): Please list ________________ Reaction ________________
☐	☐	Have you experienced a fall in the last 12 months? Please describe ________________
☐	☐	Have you ever fainted, felt dizzy or nauseous after having your blood drawn or an IV started?
☐	☐	Diabetes: If yes, do you take insulin or pills? ________________
☐	☐	Did you take your blood sugar level the day of your procedure? ________________ Time taken and results ________________
☐	☐	High blood pressure: Is your blood pressure controlled by medication? ________________
☐	☐	Do you take antibiotics prior to medical or dental procedures? Antibiotic and dose ________________
☐	☐	Heart problems ________________
☐	☐	Heart pacemaker, implanted cardiac defibrillator ________________
☐	☐	Lung disease: (such as Asthma, Emphysema) ________________
☐	☐	Sleep apnea ________________
☐	☐	Cancer – Location ________________
☐	☐	Kidney disease ________________
☐	☐	Neurological problems: (such as seizures) ________________
☐	☐	Gastrointestinal disease or symptoms: (such as reflux, Crohn's Disease, ulcerative colitis) ________________
☐	☐	Liver disease: (such as cirrhosis, hepatitis) ________________
☐	☐	Glaucoma ________________
☐	☐	I smoke/use tobacco products. If NO: Do you have a history of use? (circle one) YES / NO If YES or HISTORY: Amount per day __________ For how many years __________
☐	☐	Alcohol/substance use: How much per day? ________________ Last drink ____________
☐	☐	Have you had a hysterectomy? ________________ For women ages 12–50, when was the first day of your last menstrual period? ________________
☐	☐	Are you pregnant or trying to become pregnant? ________________
☐	☐	Is there a possibility that you might be pregnant? ________________
☐	☐	Other (such as arthritis, blood disorders, HIV, infectious diseases, breast feeding) ________________
☐	☐	Do you follow a special diet for medical reasons? (For example, gluten-free) ________________

Please list your surgeries ________________________________

____

Patient Signature ________________________ **Date** ____________ **Time** ____________

Signature of Admitting Nurse ________________________ **Date** ____________ **Time** ____________

Reviewed by Physician Signature ________________________ **Date** ____________ **Time** ____________

Northwestern Memorial Hospital

GI LABORATORY
At-Home Medications List

Dear Patient,
Please complete the Allergies and Medication sections. A staff member will review this list with you if there are any questions.
If you have questions about medications NOT prescribed during today's visit, please contact your primary care physician.

ALLERGIES: ☐ None (check the box if you do not have any allergies)

Source	Reaction	Source	Reaction
Example: Penicillin	*Hives*	3.	
1.		4.	
2.		5.	

MEDICATIONS: ☐ None (check the box if you do not take any medications, vitamins, herbals, etc) Physician/Staff Use

DRUG List the medications you are taking, include all over-the-counter medicines, vitamins, herbals, minerals, and those you may have held for today's visit.	**STRENGTH** List the strength of each tablet, capsule, etc.	**DOSE/ DOSE FORM** How many tablets, units, capsules, are you taking at one time?	**FREQUENCY** How often do you take the medication? (once a day, twice a day, etc.)	**ROUTE** How are you taking this medication? (by mouth,injection, patch, etc.)	**LAST DOSE TAKEN** Indicate the date and time you last took the medication	***Physician:*** **Please check if prescribing additions or changes to chronic medications** ***Staff:*** **If checked, refer to Instructions below. If not checked, file list**
Ex. Cardizem CD	*180 mg*	*1 capsule*	*once a day*	*by mouth*	*9 pm last night*	☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐

Date:________________________________

Do not write below this line - Hospital Staff ONLY

INSTRUCTIONS:
Staff: If, during this visit, the patient was prescribed a new medication for a chronic disease/condition or a change was made to the at-home medication regimen for a chronic disease/condition, complete the patient instructions portion below, instruct the patient regarding additions and/or changes, and provide the patient with a photocopy of this document. After completion, check box below, and file.

☐ Medication instructions were reviewed with the patient. The patient received a photocopy of this medication list.

Patient: START/RE-START taking this at-home medication(s):

Condition Medication is prescribed for:	Take this Medication at this Strength:	At this Dose/Dose Form:	How often: (Frequency)	Route:	Start taking this Medication on:	Date, if any, you should **stop** taking this medication:
					___/____/____	
					___/____/____	

Patient: STOP taking this at-home medication:

STOP taking this Medication at this Strength, Dose/Dose Form, and Frequency: ________________________________

STOP taking this Medication on:__________ /______ /__________

Additional Comments: ________________________________