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Colonoscopy Patient Discharge Information

Activities and diet after your colonoscopy

You must **not** drive on the day of your colonoscopy. **Someone must accompany or drive you home after your colonoscopy.** It is best to have someone stay with you or check in on you for the rest of the day.

You can start eating and drinking right after your colonoscopy. Eat light foods (e.g., egg on toast, pasta, rice, no spicy or fatty foods) for the rest of the day. You can take your usual medication, unless you are told not to.

For 24 hours after your colonoscopy, DO NOT:

- Drive any kind of vehicle (e.g., cars, bicycles, boats)
- Operate heavy machinery or use power tools
- Drink alcohol or take other drugs that can make you sleepy
- Make big decisions
- Exercise heavily

How you might feel after your colonoscopy

You have been given medication that makes you sleepy, so you may feel tired after your colonoscopy. You may also be more forgetful or less able to focus. Make sure you get plenty of rest for 24 hours after your colonoscopy.

You may have some mild stomach pain and cramping, bloating or a "full feeling." Peppermint tea, warm drinks, walking around or trying to pass gas can help you feel better.

You may notice a small amount of blood when you go to the washroom, either in the toilet or on your toilet paper. There can also be streaks of blood in your stool (poop). Small amounts of blood, especially in your first bowel movement, are normal after having a colonoscopy.

Other common side effects may include:

- Discomfort or soreness where the needle for your IV was put in your arm
- Soft or abnormal bowel movements
- Feeling thirsty
- Headache, feeing light-headed or sleepy

Tell your doctor, call the colonoscopy facility or go to the nearest emergency room right away if you have any of the following:

- Very bad stomach pain that does not go away
- Fever, chills or vomiting
- Chest pain
- Trouble breathing
- Large amounts of blood in your stool (bloody, black or dark red stools) within 2 weeks of your colonoscopy or symptoms that are getting worse

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What you need to do next (completed by healthcare provider)

Your medication instructions (make sure you have all the prescriptions you need from your doctor):

Restart (medication that prevents blood clots) ____________________ on ____________ (date)

Start taking these medications: ____________________

Do not take these medications: ____________________

More information: ____________________

Your follow-up plan:

- ☐ You will be contacted by (office name) ____________________ to book your next appointment
- ☐ You must book an appointment with (office name) ____________________ by calling ____________
- ☐ You do not need another appointment

Other things that need to be done (e.g., more tests, referrals, future communication): ____________________

More information or special instructions: ____________________

If you have any concerns or questions, please contact:

____________________ at ____________________

office name | phone number

Procedure details (completed by healthcare provider)

Date of procedure (MM/DD/YYYY): ______ / ______ / __________

Name of physician who performed colonoscopy: ____________________________________

Name of referring physician: ____________________________________

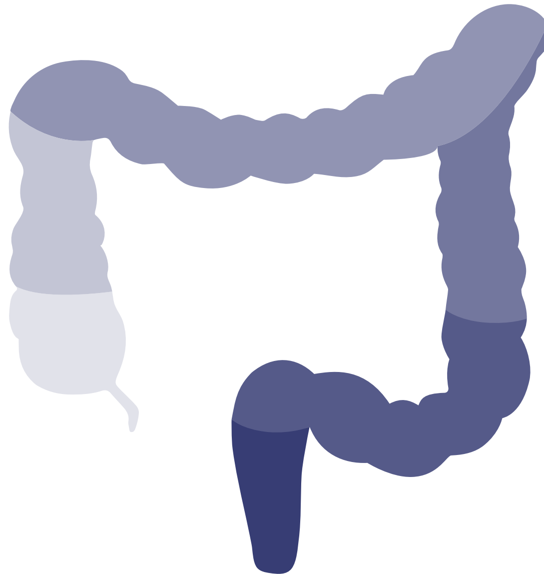
Please notify (name of facility/physician) ____
if you are required to go to hospital within 10 days because of your procedure.

Sedation used: ____

Methods used (e.g., type of intervention, techniques):

☐ Biopsy ☐ Polypectomy ☐ Other: ______________________________

Please circle the areas targeted and label as needed:



Key findings and other comments (e.g., adverse events that occurred, clips that were used, reactions to the anesthetic):

____

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____

____

Information (completed by healthcare provider)

Facility information:

Name of facility: ______________________________

Facility address: ______________________________

____

Facility telephone number: ______________________________

Patient information:

First name: ______________________________ Last name: ______________________________

Date of birth (MM/DD/YYYY): _______ / _______ / ___________

______________________________ ______________________________ ______________________________

Physician name Signature Date

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