

**KEYSTONE KIDNEY CENTER  
PRE-OPERATIVE REQUIREMENTS**

The Pre-Operative forms are to be received by Keystone one (1) week prior to treatment and must be **completed in their entirety.**

- FORMS:**
1. Patient Registration Form
  2. Physician Order Sheet signed
  3. Consent to Operation signed
  4. Patient Information Sheet signed
  5. History and Physical signed

**PRE-OP KUB**

Must be done within Four (4) weeks of ESWL

**PRE-ADMISSION TESTS (P.A.T.'s):**

Must be done within Four (4) weeks of ESWL and are to be at KKC at least four (4) business days before treatment.

**LABS REQUIRED FOR ALL PATIENTS**

1. CBC
2. Urinalysis, culture if indicated

**EKG with interpretation done within three (3) months for patients 50 years and over**

**Retreat**

Patients who are retreated.... blood work acceptable for 8 weeks and EKG for 3 months

**ADDITIONAL TESTS/REQUIREMENTS WHERE INDICATED FOR PATIENTS AT ANY AGE**

CONDITION	ADDITIONAL TEST NEEDED
Cardiovascular Disease	Cardiac Assessment/Cardiac Clearance
Pacemaker/AICD	See Additional Protocol

**DOCTOR:** PLEASE NOTE! Patients taking these medications:

Aspirin	Aspirin containing Products
Anticoagulants	Non-Steroidal Anti-Inflammatory Drugs
Herbals and Anorectics	

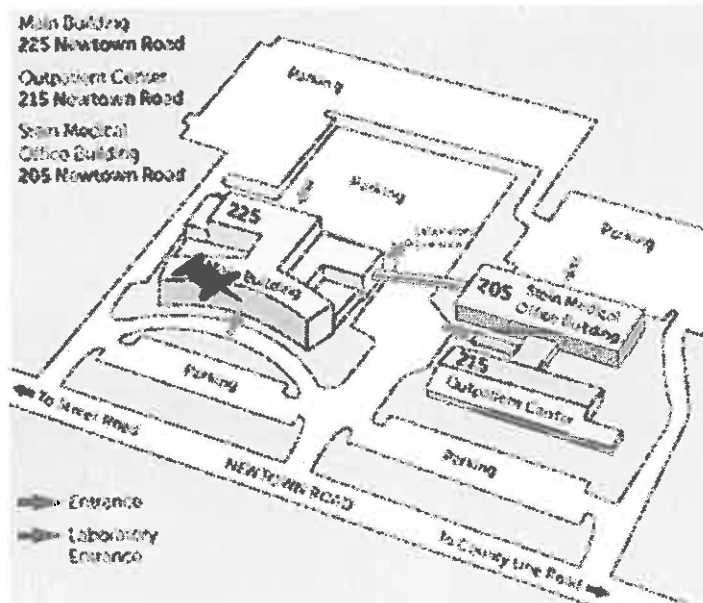
MAY INCREASE THE RISK OF COMPLICATIONS OF LITHOTRIPSY AND/OR CERTAIN ANESTHESIAS. THEY SHOULD BE STOPPED FOR 7 DAYS PRIOR TO AN ELECTIVE PROCEDURE.

MAO Inhibitors	St. John's Wart and Merida
----------------	----------------------------

MAY INCREASE THE RISK OF COMPLICATIONS OF ANESTHESIA AND SHOULD BE STOPPED FOR 2 WEEKS PRIOR TO AN ELECTIVE PROCEDURE.

**REMEMBER:** An abdomen free of both Bowel Gas and Fecal material greatly enhances visualization of calculi to be treated. Consider a bowel prep pre-op.

Thank you for the opportunity to assist in treating your patient.



**From Warminster:** Take Street Road (Route 132) East to Newtown Road. Turn right onto Newtown Road. The Health Center is one-half mile down on the left.

**From Warrington:** Take Almshouse Road East to York Road (Route 263). Turn right onto York Road and travel to Street Road (Route 132). Turn left onto Street Road and travel one-and-a-half miles to Newtown Road. Turn right onto Newtown Road. The Health Center is one-half mile down on the left.

**From PA Turnpike:** Exit the Turnpike at Willow Grove, Doylestown, Jenkintown (Exit 343). Turn right onto PA 611 N towards Doylestown. Take a sharp right onto Mill Road. Follow Mill Road till turns into N. Warminster Road. Continue on N. Warminster Road to E. County Line Road. Turn right onto E. County Line Road. Follow to Newtown Road. Turn left onto Newtown Road. The Health Center is one-half mile down on the right.

**From Bensalem/Feasterville/Southampton:** Take Street Road West to Newtown Road. Turn left onto Newtown Road. The Health Center is one-half mile down on the left.

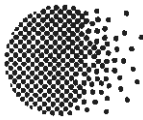
**From Bristol/Langhorne:** Take I-95 South to Street Road Exit. Turn right on Street Road West and follow for approximately 10 miles to Newtown Road. Turn left onto Newtown Road. The Health Center is one-half mile down on the left.

**ENTRANCE FOR KEYSTONE KIDNEY CENTER**

Park across from the front Main Building entrance. Enter the Main Building and take elevator down to basement. Keystone Kidney Center is located across from elevator.

**PARKING IS AVAILABLE AT NO COST**

Keystone Kidney Center  
225 Newtown Road  
Main Building, Basement  
Warminster, PA 18974



# keystone kidney center

225 newtown road • warminster, pa 18974

# PATIENT REGISTRATION FORM

### PATIENT DATA

Arrival Time \_\_\_\_\_

Anticipated Date of Service \_\_\_\_\_ Treat Time \_\_\_\_\_

Onset Date of Illness\* \_\_\_\_\_ Primary Diagnosis \_\_\_\_\_

Procedure \_\_\_\_\_

Patient Name \_\_\_\_\_ SSN \_\_\_\_\_

Retreatment [ ] Yes [ ] No Patient's Height \_\_\_\_\_ Weight \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Married / Single Birthdate \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Family Contact \_\_\_\_\_ Relationship \_\_\_\_\_ (See Employer Below)

Contact Phone (if other than above) ( ) \_\_\_\_\_

Treating Urologist \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Outpatient [ ] Inpatient [ ]

Referring Hospital \_\_\_\_\_ Room # \_\_\_\_\_

Hospital Phone ( ) \_\_\_\_\_ Contact \_\_\_\_\_

Primary/Referring Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_

\*Required for Coverage Verification

### INSURANCE

Subscriber Name \_\_\_\_\_

Primary Coverage \_\_\_\_\_ Eff. DT. \_\_\_\_\_

Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Phone/Address \_\_\_\_\_

SSN \_\_\_\_\_ Birthdate \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Secondary Coverage/Other \_\_\_\_\_ Eff. DT. \_\_\_\_\_

Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Phone/Address \_\_\_\_\_

Subscriber Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Benefits Phone ( ) \_\_\_\_\_

ATTACH PATIENT ID LABEL

NOTE: IF SUBSCRIBER IS OTHER THAN PATIENT, PLEASE INDICATE RELATIONSHIP TO PATIENT: \_\_\_\_\_

**KEYSTONE KIDNEY CENTER  
PRE-TREATMENT INSTRUCTIONS**

**FOLLOW THESE INSTRUCTIONS CLOSELY. IF YOU HAVE ANY CONCERNS OR QUESTIONS, PLEASE CALL YOUR UROLOGIST.**

1. Have your Pre-Admission Testing (PATs) performed as soon as possible, but no more than 30 days prior to your treatment, so that the results may be reviewed. Test results **MUST** be received no later than 48 hours prior to treatment day, if results are not available treatment may be cancelled.
2. Do not smoke or use chewing tobacco for 12 hours before and after your treatment. Smoking constricts blood vessels and slows circulation.
3. Do not drink any alcoholic beverages or use any illicit drugs or medications 24 hours before treatment. These may affect your anesthesia.
4. Do NOT TAKE ANY ASPIRIN, ASPIRIN CONTAINING PRODUCTS OR DRUGS CONTAINING IBUPROFEN. Take acetaminophen products (Tylenol), or ask your doctor for a recommendation for pain relief.
5. If you are taking ANTICOAGULANT MEDICATIONS, consult your urologist for instructions. All anticoagulant medications **MUST BE STOPPED** before treatment. If it is not recommended for you to stop your anticoagulant medications, you will not be a candidate for lithotripsy.
6. If you are taking medications(s) for your heart or blood pressure or other medications that you take daily, the nurse from Keystone Kidney Center will call you with instructions about how to take your medicine.
7. Do not eat or drink anything after midnight. (Including gum, mints, candy or ice chips). It is very important for the success of your treatment to follow the instructions given by the nurse. Failure to follow instructions may result in cancelling your treatment.
8. Arrange for transportation home from our treatment center, as you will be considered under the influence of anesthesia and will **not be permitted to drive yourself.** Family or friends may wait in our lounge area.  
**IF YOU DO NOT HAVE TRANSPORTATION YOUR TREATMENT WILL BE CANCELLED.**
9. Bring insurance cards, forms and/or referrals on the day of treatment.
10. Please bring your most recent x-ray of your kidney stone.
11. Leave money, jewelry and valuables at home. Wear comfortable clothing.
12. Our billing office will contact you only **IF** there are any questions or concerns regarding your insurance coverage.
13. You will receive a call from the nursing staff prior to your treatment. If it is difficult to reach you between the hours of 8am to 3pm, please call us during those hours at (215) 675-9900.

**Instructions:**

1. Please indicate medication, dose, frequency, duration and route of administration.
2. Stopping of an order should be written as a specific order.
3. All narcotic orders **MUST** contain signature and DEA number.
4. Verbal orders are written as "Verbal Order by Dr. (add name) and **MUST** include date and time verbal order was obtained". All verbal orders will be signed, dated and timed by the nurse receiving the order and witnessed by a second nurse. **ALL** verbal orders **MUST** be signed, dated and timed by the physician on the day of treatment.

**Pre-Treatment Orders:**

1. Admit Keystone Kidney Center:  
To the service of: Dr. \_\_\_\_\_  
Date of Service: \_\_\_\_\_  
Treatment to be performed: \_\_\_\_\_
2. Maintain NPO status
3. Start IV; Lactated Ringers 1 liter @125 ml/hr.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

**Allergies/Reactions:** \_\_\_\_\_

**Additional Orders:**

Date	Time	Orders

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

Patient Name \_\_\_\_\_ Date and Time of Service \_\_\_\_\_

- 1. I hereby authorize Dr. \_\_\_\_\_ and/or whomever he may designate as his assistants to perform upon me (or the patient named above) the following operation/procedure/treatment (state specific operation/procedure/treatment to be performed):  
\_\_\_\_\_

If any unforeseen condition arises during the operation, calling in his/her judgement, any additional procedures or treatments from those listed above. I further request and authorize him/her to do whatever is deemed necessary and advisable during the operation/procedure/treatment. I understand that in the event of an emergent medical situation, I might require admission to the hospital.

- 2. The nature and purpose of the operation/procedure/treatment, possible alternative methods of treatment, alternative locations (including a hospital), the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained. **In obtaining informed consent, the physician performing the operation/procedure/treatment is responsible for disclosure of the comparative risks, benefits and alternatives associated with said operation/procedure/treatment in the ASC instead of a hospital.**
- 3. I consent to the administration of anesthesia to be applied by or under the direction of one of Keystone Kidney Center's qualified Anesthesiologists, and to the use of such anesthetics as they may deem advisable.
- 4. I agree that those connected with the Anesthesia Department shall not be responsible for any damage to lose, defective or capped teeth or any denture, bridgework, or dental prothesis which are not removed before operation/procedure/treatment. My failure to disclose the presence of such items or refusal to remove the same shall constitute my acceptance of any risks associated thereto.
- 5. I consent to the examination, photographic studies, x-ray and disposal of any tissues or parts which may be removed by authorities of Keystone Kidney Center.
- 6. I certify that I have read and fully understand the above consent to operation/procedure/treatment. The explanations therein referred to were understood by me, and all questions were fully answered and understood. I certify that all blanks or statements requiring insertion or completion were filled in before I signed.

\_\_\_\_\_  
Signature or patient or representative

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date and Time

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date and Time

**PHYSICIAN'S CERTIFICATION**

I certify that I have explained the above operation/procedure/treatment and the major risks involved:

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date and Time

## KEYSTONE KIDNEY CENTER

### BOWEL PREPARATION FOR EXTRA CORPOREAL SHOCK WAVE LITHOTRIPSY

#### DAY BEFORE TREATMENT:

1. Force Fluids – Drink at least 8 – 8oz glasses of water or clear liquid.
  - a. Drinking this water is to help prevent dehydration when taking the bowel preparation. It also aids in the process of cleaning out your system.
  - b. Clear liquids include, Apple juice, Cranberry juice, White Grape juice, Tea (Hot or Iced), Coffee (Hot or Iced), Ginger Ale, Sprite, 7-UP, Coke or Pepsi, Gatorade or Powerade, Water.
    - i. **DO NOT CONSUME any Dairy, Juice with Pulp, Coffee Creamer, Half and Half.**
  - c. The number of glasses of fluid is in **ADDITION** to all other fluids taken. Patients may drink **MORE** than the number specified, but **NOT LESS**.
2. Eat a light low residue diet throughout the day.
  - a. Consume foods that are considered low residue or Clear Liquids. Foods considered low residue are White Meat Chicken or Turkey, Fish, Eggs, White Bread with **NO SEEDS** or **NUTS** (no butter), White Rice, Well Cooked Vegetables without skin or seeds, Bananas, Watermelon, Honey Dew Melon.
  - b. Foods that count as Clear Liquid are, Jell-O, Chicken Broth, Beef Broth, Vegetable Broth.
  - c. **DO NOT CONSUME any Milk or Dairy** products including Cheese, Fruit Juices that contain Pulp, Fruit Nectars, RAW Vegetables, any fruits other than what was mentioned earlier, Fried Foods, Butter, Beef, Pork, Lamb, Whole Grain Cereals or Breads, Green Leafy Vegetables, **CORN**, Popcorn.

#### NO MILK OR DAIRY PRODUCTS ALLOWED

3. At 5pm mix the **MiraLAX 238-gram bottle** with 64oz of a clear liquid (see above). Mix till fully dissolved. Drink an 8oz glass every 15 minutes until solution is gone. MiraLAX can be purchased at any drug store over the counter.
  - a. Once prep is started **DO NOT CONSUME ANY MORE FOOD!**
  - b. You are encouraged to continue to **CONSUME CLEAR LIQUIDS** till midnight.
    - i. **NOTHING TO EAT OR DRINK AFTER MIDNIGHT** – unless otherwise directed by the physician or the nurse.

#### DAY OF TREATMENT:

1. **YOU ARE TO HAVE NOTHING TO EAT OR DRINK**, unless otherwise directed by physician or nurse regarding medications. You may brush your teeth, do not swallow any water.
2. Arrive at the scheduled time, bring your insurance cards and have someone with you to take you home.

**PATIENT'S BILL OF RIGHTS****THE PATIENT HAS THE RIGHT TO:**

1. Be informed of his/her rights at the time of admission.
2. Know what rules and regulations apply to his/her conduct as a patient.
3. Have good quality care and high professional standards that are continually maintained and reviewed.
4. Medical and nursing services without discrimination based upon age, race, color, religion, sex, national origin, handicap, disability, or source of payment.
5. Upon request, to be given the names of his attending physician, the names of all other physicians directly participating in his care, and the names and functions of other health care persons providing direct care contact with the patient.
6. Choose another provider.
7. Consideration of privacy concerning his/her own medical treatment. Case discussion, consultation, examination, treatment and changing are considered confidential and shall be conducted discreetly.
8. Have records pertaining to his medical care treated as confidential except as otherwise provided by law or third party contractual arrangements.
9. Upon request, provide the patient, or patient designee to the information contained in his medical records, unless the attending practitioner for medical reasons specifically restricts access.
10. Examine and receive a detailed explanation of his/her bill.
11. Have all information concerning diagnosis, treatment, and prognosis, including information about alternative treatments and possible complications provided in layman's terms. When it is not medically advisable to give the information to the patient, the information shall be given on his/her behalf to a responsible person.
12. Refuse drugs or procedures, to the extent permitted by statute, and a practitioner shall inform the patient of the medical consequences of the patients' refusal of drugs or procedures.
13. Except for emergencies, all practitioners shall obtain the necessary informed consent prior to the start of the procedure.
14. Have access to an interpreter for any patient who does not speak English or uses sign language for all communication between physicians, nursing, and other personnel who would have contact with the patient.
15. The expectation that the ambulatory surgery center will provide information for continuing health care requirements following discharge and the instructions for meeting them.
16. Expect emergency procedures to be implemented without unnecessary delay.
17. When an emergency occurs, and the patient is to be transferred to another facility, the patient's responsible person shall be notified. The institution to which the patient is to be transferred shall also be notified prior to the patient's transfer. If necessary 911 will be called to expedite any transfer to other facility and provide continued emergency care.
18. Expect good management techniques to be implemented within the Center. These techniques shall make effective use of the patient's time and avoid the personal discomfort of the patient.
19. Information on the grievance procedure to resolve a complaint or concern and to know that presentation of such will not compromise the present or future care of the patient.
20. Contact the Clinical Nurse Manager or Executive Director of Keystone to discuss any grievance at the phone number listed above. If necessary the patient may contact the Department of Health Hotline at 1-800-254-5164 or contact Medicaid at <https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Grievances.html> to file any grievance.

**THE PATIENT HAS THE RESPONSIBILITY TO:**

1. Provide accurate information about their health, medications taken, allergies and sensitivities.
2. Question the physician, nursing, administration and/or staff if any procedure, treatment, form, or information is unclear and requires further explanation for clarification.
3. Be courteous to our staff and other patients or visitors.
4. Inquire about policies concerning referrals, fees and payments that are the responsibility of the patient and/or responsible party.
5. Seek, if necessary, appropriate emergency medical care post treatment via the treating physician and/or the patient's local hospital emergency room.
6. Provide post procedure transportation from the Center to their home or care facility by someone other than themselves. NOTE: PATIENT WILL NOT BE PERMITTED TO DRIVE HIM/HERSELF HOME AFTER PROCEDURE.



**KEYSTONE MOBILE PARTNERS  
225 NEWTOWN RD, WARMINSTER, PA 18974  
215-675-9900 – FAX 215-675-4096**

***Extracorporeal Shock Wave Lithotripsy Patients:***

***Please follow these special instructions concerning Aspirin, Ibuprofen, Prescription Blood Thinners, Vitamins and Herbal Supplements.***

If you have any questions regarding any medications, please contact your physician, pharmacists or please feel free to call us directly and ask to speak with a nurse at 215-675-9900 M-F 9-5.

**!!ASPIRIN (81-325-650MG), ASPIRIN CONTAINING PRODUCTS, MOTRIN, ADVIL, IBUPROFEN OR NSAID CONTAINING PRODUCTS MUST BE STOPPED 7 DAYS PRIOR TO TREATMENT. FAILURE TO STOP THESE MEDICATIONS WILL RESULT IN THE CANCELLATION OF YOUR PROCEDURE!!**

***The first stopped day is the first day that you DID NOT take the medication. The last day is the day BEFORE your treatment.***

**PRESCRIPTION ANTICOAGULANT MEDICATION:**

The following list is the minimum required number of days to stop these medications prior to your treatment. Please check with your prescribing physician to determine if it will be safe for you to stop these medications for the number of listed days. If it is deemed unsafe, by your prescribing physician, to stop these medications, you will not be a candidate for (ESWL) lithotripsy. These medications **MUST** be stopped for the number of listed days prior to your treatment. **Failure to stop these medications will result in the cancellation of your procedure.**

Aggrenox (Dipyridamole/Aspirin) – **STOP 7 DAYS**  
Brilinta (Ticagrelor) – **STOP 5 DAYS**  
Coumadin (Require PT/INR  $\leq$  1.1) – **STOP 5 DAYS**  
Eliquis (Apixaban) – **STOP 3 DAYS**  
Effient (Prasugrel) – **STOP 7 DAYS**  
Lovenox – **STOP 24 HOURS**  
Persantine (Dipyridamole) – **STOP 24 HOURS**

Plavix – **STOP 7 DAYS**  
Pletal – **STOP 5 DAYS**  
Pradaxa – **STOP 3 DAYS**  
Savaysa (Edoxaban) – **STOP 3 DAYS**  
Ticlid (Ticlopidine HCL) – **STOP 10 DAYS**  
Xarelto – **STOP 2 DAYS**

The following list of medications contain ingredients that may interfere with your blood's ability to clot. **You must discontinue the use of these medications 7 days prior to your lithotripsy procedure.**

**!! FAILURE TO STOP THESE MEDICATIONS WILL RESULT IN THE CANCELLATION OF YOUR PROCEDURE!!**

Please be advised that ALL medications should be discussed with your physician prior to lithotripsy. These include ALL prescription medications and ALL over-the-counter (OTC) medications.

**NONSTEROIDAL ANTIINFLAMMATORY MEDICATIONS (NSAID):**

\*There are many over-the-counter (OTC) products that contain this type of medicine and if your medication is not listed please consult your physician as to the need to stopping prior to your treatment\*

GENERIC NAME	BRAND NAME
Celecoxib	Celebrex
Diclofenac	Arthotec, Cambia, Cataflam, Dyloject, Flector, Pennsaid, Solaraze, Volataren, Voltaren XR, Zipsor, Zorvolex,
Diflunisal	Dolobid
Etodolac	Lodine, Lodine XL
Fenoprofen	Fenortho, Nalfon, Nalfon 200, ProFen
Flurbiprofen	Ansaid
Ibuprofen	Actiprofem, Addaprin, Advil (all varieties), Caldolor, Combunox, Dristan Sinus, Duexis, Genpril, Haltran, IBU (all varieties), Ibuprohm, I-Prin, Medipren, Menadol, Midol IB, Motrin (all varieties), NeoProfenm, Nuprin, Proprinal, Q-Profen, Reprexain, Rufen, Saletto (all varieties), Trendar, Vicoprofen
Indomethacin	Indocin, Indocin SR, Indo-Lemmon, Indomethagan, Tivorbex
Ketorolac	Sprix, Toradol
Ketoprofen	Orudis, Orudis KT, Oruvail
Mefenamic Acid	Meclodium, Meclofenamate, Meclomen, Ponstel
Meloxicam	Mobic, Omiiz ODT, Vivlodex
Nabumetone	Ralafen
Naproxen	Aflaxen, Aleve (all varieties), All Day Pain Relief, Anaprox, Anaprox DS, Flanax Pain Reliever, Midol ER, Naprelan, Naprosyn, Naprosyn EC, Naproxen, Prevacid Naprapac, Treximet, Vimovo
Oxaprozin	Daypro
Piroxicam	Feldene
Sulindac	Clinoril
Tolmetin	Tolectin, Tolectin 600, Tolectin DS

The following list of medications contain ingredients that may interfere with your blood's ability to clot. **You must discontinue the use of these medications 7 days prior to your lithotripsy procedure.**

**!! FAILURE TO STOP THESE MEDICATIONS WILL RESULT IN THE CANCELLATION OF YOUR PROCEDURE!!**

Please be advised that ALL medications should be discussed with your physician prior to lithotripsy. These include ALL prescription medications and ALL over-the-counter (OTC) medications.

**ASPIRIN (ASA) and SALICYLATE MEDICATIONS:**

\*There are many medications that contain Aspirin (ASA) and Salicylate under many different names. If your medication is not listed, please consult your physician as to the need to stopping prior to your treatment. If you are not sure if your medication contains Aspirin or Salicylate please contact your physician or pharmacists to determine if your medication contains either of those ingredients. \*

<b>ASPIRIN (ASA) or ASPRIN COMPOUND MEDICATIONS</b>	<b>ASPIRIN (ASA) or ASPRIN COMPOUND MEDICATIONS</b>	<b>MAGNESIUM SALICYLATE</b>
Acetylsalicylic Acid	Lortab ASA	Doan's Pills (all varieties)
Acuprin	Meprobamate Aspirin (Equagesic)	Choline Magnesium Trisalicylate
Aggrenox	Norgesic (all varieties)	Mobidin
Alka Seltzer (all varieties)	Orphenadrine	Mobigesic
Anacin (all varieties)	Orphengesic	Nuprin Backache
Arthritis Pain	Pamprin (all varieties)	Tricosal
Ascriptin (all varieties)	Percodan	Trilisate
Asper-gum	Roxiprin	
Aspirin (all varieties, all brands (name or store brand), ALL doses, enteric or non-enteric coated	Soma Compound	<b>SALSALATE</b>
Aspirin/Oxycodone (all brands)	St. Joseph Aspirin (all varieties)	Disalcid
Asprimox	Synalgos-DC	Salflex
Bayer Aspirin (all varieties)	Trigesic	Salsitab
Bufferin (all varieties)	Vanquish	Sodium Salicylate
Darvon-N-Compound	Zorprin	
Doxaphene Compound		
Durlaza		
Ecotrin (all varieties)		
Empirin/Codeine		
Entercote		
Fiornial		
Genacote		

The following list of vitamins and herbal supplements contain ingredients that may interfere with your blood's ability to clot. **You must discontinue the use of these medications/supplements 7 days prior to your lithotripsy procedure.**

**Please be advised that ALL medications should be discussed with your physician prior to lithotripsy. These include ALL prescription medications and ALL over-the-counter (OTC) medications.**

**\*There are many over-the-counter (OTC) products that contain ingredients that can cause bleeding during and after surgery and if your medication/supplement is not listed please consult your physician as to the need to stopping prior to your treatment\***

### **VITAMINS and HERBAL SUPPLEMENTS:**

Dehydroepiandrosterone (DHEA)

Eicosapentaenoic Acid (EPA)

Fish Oils (Omega-3 Fatty Acids)

Garlic Supplement

Lovaza

Onion Supplement

Vitamin E

## **MEDICATIONS TO HOLD MORNING OF PROCEDURE**

### **ACE INHIBITORS (ANGIOTENSIN CONVERTING ENZYME INHIBITORS)**

Benazepril (Lotensin, Lotensin HCT)	Captopril (Capoten)
Enalapril (Vasotec)	Fosinopril (Monopril)
Lisinopril (Prinivil, Zestril)	Moexipril (Univasc)
Perindopril (Aceon)	Quinapril (Accupril)
Ramipril (Altace)	Trandolapril (Mavik)

### **ANGIOTENSIN RECEPTOR BLOCKERS (ARBs)**

Candesartan (Atacand)	Candesartan-Hydrochlorothiazide (Atacand HCT)
Eprosartan (Teveten)	Eprosartan-Hydrochlorothiazide (Teveten HCT)
Irbesartan (Avapro)	Irbesartan-Hydrochlorothiazide (Avalide)
Losartan (Cozaar)	Losartan-Hydrochlorothiazide (Hyzaar)
Olmesartan (Benicar)	Olmesartan-Hydrochlorothiazide (Benicar HCT)
Olmesartan-Amlodipine (Azor)	Telmisartan (Micardis)
Telmisartan-Amlodipine (Twynta)	Telmisartan-Hydrochlorothiazide (Micardis HCT)
Valsartan (Diovan)	Valsartan-Amlodipine (Exforge)
Valsartan-Hydrochlorothiazide (Diovan HCT)	
Valsartan-Amlodipine-Hydrochlorothiazide (Exforge HCT)	

### **ORAL DIABETIC MEDICINE**

Hold all Oral Diabetic Medicine

### **INJECTABLE DIABETIC MEDICINE**

Hold all Injectable Diabetic Medicine (Consult your Endocrinologist for specific instructions)