EGD with BRAVO Monitoring Procedure Information

Are there any medications I need to stop taking before my procedure?

You must stop taking acid reducing medicine seven days before your procedure.

What happens during your EGD with BRAVO placement test?

When you arrive, the nurse will explain what will happen before, during, and after the EGD with BRAVO placement test. Please ask the nurse if you have questions.

The nurse will start an IV to give you medicine that will make you sleepy and relaxed. A mouthpiece will keep your mouth open, and a capsule about the size of a pencil eraser will be attached to the lower lining of your esophagus. You will be monitored closely throughout the study.

You will need to rest after the EGD with BRAVO placement test. Your doctor will determine when you are able to go home.

What do you need to do from home after the procedure?

Once attached to your esophagus, the BRAVO capsule measures pH levels via signals to a BRAVO receiver that’s about the size of a cell phone and can be attached to your waistband or belt. You will always need to keep the receiver within three feet of you. You can shower.
and bathe, but make sure the receiver is within three feet of you without getting wet.

Along with the BRAVO receiver, you will also be given a diary to track your symptoms, eating schedule, and body position. You should return the transmitter and diary to Benefis Gastroenterology after 48 hours, and if you do not drop them off, you will be responsible for the insurance and mailing of the transmitter and diary.

It is important that you maintain all regular activities as much as possible to obtain an accurate assessment of your reflux throughout a routine 48-hour period. This includes maintaining typical meals, activities, exercise, sleep, etc. while the BRAVO capsule and receiver are in place.

**What happens to the BRAVO capsule?**

Several days after the study, the capsule will naturally detach from the esophagus and pass through your digestive tract.
Name: ____________________________ Age:_________
Primary Provider:_______________________Date:_________
Reason for your visit today:_____________________________

**Circle Problems You are Having**

- Weight gain, weight loss, fatigue, fever, night sweats
- Poor vision, eye pain, red eyes
- Hearing loss, sore throat, hoarseness, dentures, loud snoring
- Chest pain, heart murmur, heart valve, ankle swelling
- Shortness of breath, wheezing, coughing, sleep apnea
- Abdominal pain, loss of appetite, trouble swallowing, indigestion, heartburn, liver problem, constipation, diarrhea, change in bowel movements, nausea, vomiting, rectal bleeding, hemorrhoids, bloating, vomited blood
- Painful urination, frequent urination, urination at night, blood in urine, kidney stones
- Arthritis, back pain, artificial joint
- Rash, hives, breast lump
- Headaches, dizziness, weakness, seizures, numbness or tingling, change in speech
- Anxiety, depression, mood change, difficulty sleeping, crying spells, memory loss
- Thyroid trouble, diabetes
- Anemia, increased bleeding/bruising, enlarged glands

**List Medication Allergies**

1. ____________________ 3. ____________________
2. ____________________ 4. ____________________

Previous reaction to anesthetic or sedative?  Yes  No

**List Operations and Approximate Year**

1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________

**List Operations and Approximate Year**

1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________

**List Other Diseases and Illnesses**

1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________

Have you recently used aspirin, Anacin, Alka-Seltzer, Bufferin, Excedrin, Vanquish or arthritis medications such as Advil, Motrin, Nuprin, or Aleve?  Yes  No

**List Medications (Include vitamins and supplements.)**

1. ____________________ 5. ____________________
2. ____________________ 6. ____________________
3. ____________________ 7. ____________________
4. ____________________ 8. ____________________

Do you take antibiotics for dental work or because of a heart murmur?  Yes  No

**Social History**

☐ Single  ☐ Married  ☐ Divorced  ☐ Separated  ☐ Widowed

Occupation:____________________________________

Employer:_____________________________________

Hobbies:______________________________________

Who lives with you?:_____________________________________

**Family Health**

(List Illnesses. If no longer living indicate age and cause of death.)

Father:__________________________________________

Mother:__________________________________________

Brothers:________________________________________

Sisters:__________________________________________

Children:________________________________________

Other relatives:__________________________________

**Family Health (Indicate which relatives have the conditions.)**

Colon Cancer:___________________________________

Colon Polyps:___________________________________

Gallstones:_____________________________________

Pancreatitis:____________________________________

Liver Disease:___________________________________

Colitis or Chron’s Disease:_________________________

**Smoking**

☐ Yes  ☐ No  Packs/day:___  Years smoked:_____

**Drinking**

☐ Yes  ☐ No  Drinks/day:____________

**Last menstrual period (women):______________________

**Recent travel:__________________________________

**Provider Comments - ROS (Level 3 = 2-9 areas, Level 4/5 = 10+ areas)**

☐ All other systems negative

Provider Signature

Date

**Date Reviewed/Updated**

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