

Dr. Alkotob Dr. Abed Dr. Issawi



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To: _____ DOB: _____ Date: _____

Arrangements have been made for your HEART CATHERIZATION/ ARTERIOGRAM and *possible* ANGIOPLASTY/STENT/ATHERECTOMY/ ROTABLATOR on

_____ (date and time of scheduled procedure)

Sign in no later than _____ A.M/P.M. at
_____ McLaren Regional Medical Center, Patient Registration on the 1st floor
_____ Hurley Medical Center 1st Floor Admitting
_____ Genesys Regional Medical Center

If you have a dye allergy (or you are allergic to seafood, shellfish, or iodine), notify our office immediately.

If you take PRADAXA, XARELTO, COUMADIN or WARFARIN, **stop** taking it **four days prior to the procedure**.

Continue taking all of your other medications. Bring your medications with you, along with a list of medications you take.

Continue taking aspirin as prescribed, including the day of the procedure. If you are not taking aspirin, begin to take one adult aspirin per day upon receipt of this letter. If adult aspirin causes stomach upset, take one baby aspirin.

DO NOT eat or drink anything after midnight prior to the procedure; *you may have a couple small sips of water to take your medications on the morning of the procedure.*

If you are a diabetic and take GLUCOPHAGE OR GLUCOVANCE (Metformin or Sulfonylurea) you must **stop the medication 2 days before the procedure. You may resume taking the medication 2 days after your procedure unless directed otherwise.**

Also, if you are diabetic, do not take Glimepiride, Insulin or oral hypoglycemic(s) the morning of the procedure, unless otherwise instructed by our office.

Enclosed are **PRE-TEST ORDERS** to be done 4 to 7 days prior to your procedure.

Someone *must* accompany you to the hospital and take you home after the procedure. You may be kept overnight. Results will be discussed with you before discharge. A report and recommendations will be mailed to your family physician as soon as possible.

Our office will provide educational information regarding this procedure.

Latex Allergy? _____