

ADULT TEST INSTRUCTIONS / NAME: _____

YOU MUST BRING THIS REQUEST WITH YOU TO THE APPOINTMENT. FAILURE TO DO SO WILL RESULT IN A DELAY IN YOUR APPOINTMENT.

<input type="checkbox"/> KIDNEY ULTRASOUND	DATE:	TIME:	PHYSICIAN
PREP: <ul style="list-style-type: none"> ○ IF POSSIBLE DRINK 1 (ONE) EIGHT OUNCE GLASS OF WATER. ONE HOUR PRIOR TO APPOINTMENT. THIS HYDRATES YOUR KIDNEY FOR BETTER VISUALIZATION. 			
<input type="checkbox"/> SCROTAL ULTRASOUND	DATE:	TIME:	PHYSICIAN
PREP: <ul style="list-style-type: none"> ○ NO PREPARATION REQUIRED 			
<input type="checkbox"/> PELVIC OR BLADDER ULTRASOUND	DATE:	TIME:	PHYSICIAN
PREP: <ul style="list-style-type: none"> ○ DRINK 32 OZ. OF LIQUID. FINISH DRINKING ONE (1) HOUR BEFORE TESTING ○ DO NOT URINATE UNTIL THE TEST IS COMPLETED 			
<input type="checkbox"/> PROSTATE ULTRASOUND	DATE:	TIME:	PHYSICIAN:
PREP: PATIENTS WITH INDWELLING CATHETER DO NOT CLAMP OR PLUG CATHETER <ul style="list-style-type: none"> ○ TAKE ONE MINERAL OIL ENEMA TWO (2) HOURS BEFORE TEST. DO NOT EAT AFTER THE ENEMA ○ DRINK 16 OZ. OF WATER. FINISH DRINKING ONE (1) HOUR BEFORE TESTING ○ DO NOT URINATE UNTIL AFTER TEST IS COMPLETE ○ IF YOU ARE UNABLE TO ADMINISTER A MINERAL OIL ENEMA PLEASE DO THE FOLLOWING: THE DAY BEFORE THE TEST, CLEAR LIQUIDS ONLY. IN THE PM 2 (TWO) DUCOLAX TABLETS. THE DAY OF THE TEST CONTINUE CLEAR LIQUIDS. IN THE AM TAKE 1 (ONE) DUCOLAX TABLET. DRINK 16 OZ. OF WATER, FINISH DRINKING ONE HOUR BEFORE TESTING. 			
<input type="checkbox"/> COMPLETE ABDOMINAL ULTRASOUND	DATE:	TIME:	PHYSICIAN
PREP: <ul style="list-style-type: none"> ○ NOTHING TO EAT OR DRINK EIGHT (8) HOURS PRIOR TO TESTING. 			
<input type="checkbox"/> PENILE ULTRASOUND	DATE:	TIME:	PHYSICIAN
PREP: <ul style="list-style-type: none"> ○ NO PREPARATION REQUIRED. 			
<input type="checkbox"/> UROFLOW	DATE:	TIME:	PHYSICIAN
PREP: <ul style="list-style-type: none"> ○ DRINK 32 OZ. OF LIQUID. FINISH DRINKING ONE (1) HOUR PRIOR TO TESTING ○ DO NOT URINATE UNTIL TEST IS COMPLETE 			
<input type="checkbox"/> PVR	DATE:	TIME:	PHYSICIAN
PREP: <ul style="list-style-type: none"> ○ NO PREPARATION REQUIRED. 			

<input type="checkbox"/> URODYNAMICS	DATE:	TIME:	PHYSICIAN
PREP: <ul style="list-style-type: none"> ○ PLEASE COME TO THE APPOINTMENT WITH A FULL BLADDER. PLEASE DO NOT EMPTY YOUR BLADDER BEFORE TESTING. ○ IF YOU HAVE AN INDWELLING CATHETER OR SELF-CATH DISREGARD THE ABOVE. ○ IF YOU ARE PRONE TO CONSTIPATION OR ARE CONSTIPATED, PLEASE PERFORM A LIGHT BOWEL PREP 2 (TWO) HOURS PRIOR TO TESTING. ○ IF YOU PRE-MEDICATE PRIOR TO DENTAL VISITS OR HAVE ANY IMPLANTS OR REPLACEMENTS AND NEED TO PRE-MEDICATE PLEASE INFORM YOUR PHYSICIAN. ○ IF YOU TAKE BLADDER MEDICATION, PLEASE CHECK WITH YOUR DOCTOR TO SEE IF IT SHOULD BE STOPPED PRIOR TO TESTING. ○ CERTAIN PATIENTS MAY BE GIVEN A SHORT COURSE OF ANTIBIOTICS AFTER THE PROCEDURE TO PREVENT INFECTION. ○ PLEASE BE ADVISED; A CATHETER WILL BE INSERTED INTO YOUR BLADDER; A CATHETER MAY BE INSERTED INTO YOUR RECTUM. ○ IF YOU SUSPECT A BLADDER INFECTION, PLEASE NOTIFY OUR OFFICE BEFORE THE DAY OF THE TEST FOR INSTRUCTIONS AND POSSIBLE TREATMENT. WE WILL NOT PERFORM THIS TEST WITH AN UNTREATED INFECTION. ○ YOU MAY EAT NORMALLY AND TAKE ALL REGULAR MEDICATIONS. ○ THERE IS NO "PASSING" OR "FAILING" OF THE TEST. RELAX AND DO YOUR BEST. 			
<input type="checkbox"/> MALE REPRODUCTIVE SPECIMEN COLLECTION & TESTING SCHEDULE	DATE:	TIME:	PHYSICIAN
PREP: <ul style="list-style-type: none"> ○ AN APPOINTMENT MUST BE MADE AT THE ST. CLAIR SHORES OFFICE 586-771-4820 OR THE ORCHARD LAKE OFFICE 248-539-9036 FOR THIS TEST. ○ ABSTAIN FROM EJACULATION THREE (3) DAYS PRIOR TO COLLECTING SPECIMEN. ○ SPECIMEN MUST BE COLLECTED IN THE CONTAINER RECEIVED FROM THE OFFICE. SPECIMEN CANNOT BE COLLECTED IN A CONDOM. ○ SPECIMEN CONTAINER MUST BE LABELED WITH NAME, DATE, AND TIME OF COLLECTION. ○ SPECIMEN MUST BE KEPT AT OR NEAR BODY TEMPERATURE (98 DEGREES F). EXTREME CHANGES IN TEMPERATURE, EITHER HOT OR COLD, MAY ALTER THE RESULTS. ○ SPECIMEN MUST BE RECEIVED IN THE OFFICE WITHIN ONE (1) HOUR AFTER COLLECTION. 			
<input type="checkbox"/> CYSTOSCOPY	DATE:	TIME:	PHYSICIAN
NO PREPARATION REQUIRED. IF YOU HAVE BEEN DIAGNOSED WITH A MITRAL VALVE PROLAPSE YOU MUST CONTACT YOUR PRIMARY CARE PHYSICIAN OR CARDIOLOGIST FOR PROPHYLACTIC MEDICATIONS.			
<input type="checkbox"/> CYSTO / BLADDER BIOPSY	DATE:	TIME:	PHYSICIAN
NO PREPARATION REQUIRED. IF YOU ARE TAKING ASPIRIN OR ANTICOAGULANTS (BLOOD THINNERS) THESE MEDICATION MUST BE STOPPED 7 DAYS PRIOR TO YOUR PROCEDURE OR UNDER THE DIRECTION OF YOUR PRIMARY CARE PHYSICIAN OR CARDIOLOGIST. IF YOU HAVE BEEN DIAGNOSED WITH A MITRAL VALVE PROLAPSE YOU MUST CONTACT YOUR PRIMARY CARE PHYSICIAN OR CARDIOLOGIST FOR PROPHYLACTIC MEDICATIONS.			