
GASTROINTESTINAL

ASSOCIATES, Inc.

Practice Limited to Gastroenterology

Open Access Colonoscopy Questionnaire

Gastrointestinal Associates has developed a program which allows healthy individuals to schedule screening colonoscopy without the need for an office visit before the procedure.

Please complete the following questionnaire and the attached forms, and return to our office via mail or fax. **Someone from our office will contact you within 2 weeks.**

1. How old are you now?
2. Have you had a colonoscopy in the past?
 - a. If the answer is yes, please provide the name and phone number of the physician who performed the procedure, as well as the date.
 - b. If the procedure was not done by Gastrointestinal Associates, please obtain a copy of the procedure report and any biopsy results. **We cannot schedule open access colonoscopy without this information.**
3. If colonoscopy was recommended because of family history of colon cancer or polyps, which relative had cancer or polyps and how old were they?
4. Do you have any gastrointestinal symptoms such as abdominal pain, bleeding, weight loss, difficulty swallowing, diarrhea or constipation?
5. Do you have or have been treated for any of the following?

a. ulcerative colitis or Crohn's disease	yes <input type="checkbox"/>	no <input type="checkbox"/>
b. heart attack, irregular heartbeat, coronary artery bypass or stent placement, stroke, seizure, congestive heart failure or fainting spells	yes <input type="checkbox"/>	no <input type="checkbox"/>
c. renal failure or dialysis	yes <input type="checkbox"/>	no <input type="checkbox"/>
d. sleep apnea or respiratory problems (COPD, emphysema, home oxygen or active asthma)	yes <input type="checkbox"/>	no <input type="checkbox"/>
e. defibrillator, pacemaker, or artificial heart valve	yes <input type="checkbox"/>	no <input type="checkbox"/>
f. organ transplant other than cornea	yes <input type="checkbox"/>	no <input type="checkbox"/>
g. diabetes	yes <input type="checkbox"/>	no <input type="checkbox"/>
h. bleeding disorders	yes <input type="checkbox"/>	no <input type="checkbox"/>
i. hypertension	yes <input type="checkbox"/>	no <input type="checkbox"/>

Name _____ Date of Birth _____

6. Do you: Smoke? yes no Drink alcohol? yes no
Use any illicit drugs? yes no
Alcohol intake: Daily _____ Weekly _____ Monthly _____

7. Do you have any medication allergies? Please list.

8. Do you take any blood thinners other than aspirin? Yes No

9. List all medications that you take including herbals and over the counter medications:

10. Have you had difficulty with anesthesia other than nausea? Yes No

11. Have you ever had any of the following surgeries?

a. gastric bypass	yes <input type="checkbox"/>	no <input type="checkbox"/>
b. other obesity surgery	yes <input type="checkbox"/>	no <input type="checkbox"/>
c. colon surgery	yes <input type="checkbox"/>	no <input type="checkbox"/>
d. appendectomy (appendix removal)	yes <input type="checkbox"/>	no <input type="checkbox"/>
e. cholecystectomy (gallbladder removal)	yes <input type="checkbox"/>	no <input type="checkbox"/>
f. hysterectomy	yes <input type="checkbox"/>	no <input type="checkbox"/>
g. Cesarean section	yes <input type="checkbox"/>	no <input type="checkbox"/>
h. tonsillectomy	yes <input type="checkbox"/>	no <input type="checkbox"/>
i. any other surgery: _____		

12. Are you able to walk without help? Yes No

13. What is your height? _____ What is your weight? _____

Gastrointestinal Associates (OAC)
1095 Rydal Road, Suite 100
Rydal, PA. 19046
Phone: 267-620-1100
Fax: 267-620-1188

Gastrointestinal Associates (OAC)
1600 Horizon Drive, Suite 105
Chalfont, PA 18914
Phone: 215-348-7238
Fax: 215-348-3780

Name _____ Date of Birth _____

(OAC Questionnaire updated 9/18)

GASTROINTESTINAL
A S S O C I A T E S, Inc.

Practice Limited to Gastroenterology

Patient Statement for Open Access Colonoscopy:

I have reviewed the Open Access Colonoscopy Questionnaire and have answered all questions truthfully to the best of my knowledge.

- Open Access Colonoscopy is designed to allow healthy, age appropriate patients to have a screening colonoscopy without an office visit. The Questionnaire that I have completed will be carefully reviewed and I may be called for points of clarification. For my safety, depending on the answers provided, I understand I may be scheduled directly for a Screening Colonoscopy or if I do not meet open access criteria, an office visit will be scheduled.
- I understand that by choosing to pursue Open Access Colonoscopy I have not, nor during this process will I have, a GI consultation. I understand that I have the choice to make an appointment for an office visit to discuss colonoscopy and have declined to do so. I also understand that I will require a separate office visit to address any GI complaints I might have.
- If I am scheduled directly for a Screening Colonoscopy I will be sent information by mail regarding preparation for the procedure, the procedure itself, and post-procedure concerns. I will read the information provided and make sure that I understand and will be able to comply with the instructions given.
- I understand that, while not likely, there are risks involved with colonoscopy as with any medical procedure. These risks are outlined in the information that I have received. I have reviewed this information to my complete satisfaction and I understand the risks and the benefits of colonoscopy.
- Should I have any changes in my health status or insurance after being scheduled, or any questions about the information I receive by mail I will call the office at 267-620-1100.
- I understand that I must have someone drive me to the procedure and wait in the unit to drive me home. Without a driver in attendance the procedure will be cancelled.

Patient Signature: _____ Date of Birth: _____

Date: _____ Print name: _____

**GASTROINTESTINAL ASSOCIATES, INC.
PATIENT REGISTRATION**

Welcome to our practice. Please complete all sections of this registration form. Thank you.

Patient Information

Last Name _____ First _____ MI _____

Address _____ Apt.# _____

City _____ State _____ Zip Code _____

Sex: M F Marital Status: Single Married Other Student: FT PT

Employed By _____

Email Address _____ Cell Phone# _____

Home Phone# _____ WorkPhone# _____

Date of Birth _____

Emergency Contact Name _____ Relation _____ Phone _____
(Other than numbers listed above)

Federal Government Requirement: Race _____ Language Spoken _____

Ethnicity: Circle: Hispanic or Latino Non-Hispanic or Non-Latino

Pharmacy Name, Address, Phone#, Fax#: _____

Mail Order Pharmacy Name, Address, Phone#, Fax#: _____

PLEASE BRING ALL MEDICINE BOTTLES TO YOUR APPOINTMENT

Referral Information

Primary Care Physician _____

Address _____ Telephone# _____

Insurance Company Information

Patient's Relationship to Insured Party (Circle One): Self Child Wife Husband Other

Primary Insurance Co. _____ **ID#** _____

Secondary Insurance Co. _____ **ID#** _____

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE THIS INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION, HEALTH CARE FINANCING ADMINISTRATION, MY INSURANCE COMPANY OR ITS INTERMEDIARIES OR CARRIERS, OR TO THIS PHYSICIAN'S OFFICE OR TO MY ATTORNEY OR OTHER DOCTOR'S OFFICE.

I AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS AND/OR SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE, AND ANY OTHER HEALTH PLAN TO GASTROINTESTINAL ASSOCIATES, INC. I ALSO PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE.

DATE _____ SIGNATURE _____

(3/14)



COLONOSCOPY INFORMATION SHEET

This information sheet is provided to help you understand colonoscopy. If you have questions after reading this sheet, please do not hesitate to ask them. Upon your arrival at the facility for your procedure you will be asked to sign a consent form.

WHAT IS COLONOSCOPY?

Colonoscopy is an examination of the large intestine using a flexible tube (colonoscope) with a video camera at the end. The tube is inserted into the rectum and advanced through the colon. At the time of the examination the doctor can take tissue samples (biopsies) or remove abnormal growths such as polyps. Other procedures are sometimes performed such as applying clips or electrocautery to prevent or control bleeding, or injecting fluid or dyes into the bowel wall. Patients usually receive a sedative medication injected through an intravenous line (IV) and are sleepy or asleep throughout the procedure. On average, the procedure takes between 20 minutes and an hour.

WHY IS COLONOCOPY DONE?

Colonoscopy is done to detect colon cancer or pre-cancerous polyps in both average risk individuals and in those with an increased risk of colon cancer, such as those with a family history of colon cancer or a personal history of inflammatory bowel disease. It is also done as part of the evaluation of symptoms such as rectal bleeding, diarrhea, change in bowel habits, and other conditions.

WHAT IS THE SUCCESS RATE OF COLONOSCOPY?

An examination of the entire colon is possible in most patients. Occasionally a complete examination is not possible because of narrowing of the colon, the presence of an unusually long and twisty colon, or looping and sharp angulation (usually from scarring related to previous surgery or diverticulitis). Even when the entire colon can be reached with the colonoscope, there is a chance that a polyp or other abnormality will not be seen. This chance is higher when pre-colonoscopy cleansing of the colon is not adequate, but still exists even when the colon is well prepared. If the examination is incomplete, you may need additional testing such as barium enema x-ray or CT colonography (“virtual colonoscopy”), or perhaps another colonoscopy.

WHAT ARE THE RISKS OF COLONOSCOPY AND ASSOCIATED PROCEDURES?

Colonoscopy is considered a relatively safe procedure, but serious complications occur in about 1 person out of 1000 (0.1%). These complications include infection, perforation (puncture or tear of the bowel wall creating a hole), bleeding (frequently from a treatment site, such as the place where a polyp was removed), cardiac problems such as heart attack or rhythm disturbances, sedation related complications such as aspiration or decreased respiration, and even death which is quite rare. While a complete listing of possible rare complications would be quite lengthy, this list includes some of the most significant risks.

WHAT ARE THE ALTERNATIVES TO COLONOSCOPY?

There are several other methods which can be used to examine the bowel. These include a limited examination which is confined to the rectum and lowest portion of the colon (flexible sigmoidoscopy), barium enema x-ray, and CT colonography (“virtual colonoscopy”). Examination of the stool for the presence of microscopic amounts of blood can be used as a screening technique for colon cancer.

WHAT CAN I EXPECT AFTER THE PROCEDURE?

You may feel bloated or have cramping for 1-2 hours after the procedure is completed. You may feel tired and need to take a nap once you are back home. It is common to go for a day or two without a bowel movement. If biopsies are done or a polyp is removed, you may see a small amount of bleeding from the rectum. You should plan to eat a light meal after the procedure, and then return to a normal diet if you are feeling fine. You should be completely recovered and able to return to your usual activities by the next day. You cannot drive for a minimum of 12 hours after your sedated procedure.