

# Gastrointestinal Associates, Inc.

## Open Access Colonoscopy Questionnaire

**This form may be completed online at [www.gastropa.com](http://www.gastropa.com)**

Gastrointestinal Associates has developed a program which allows healthy individuals between the age of 45 and 70 to schedule screening colonoscopy without the need for an office visit before the procedure.

**EVERY QUESTION MUST BE ANSWERED OR WE WILL NOT BE ABLE TO SCHEDULE AN OPEN ACCESS COLONOSCOPY. Be advised that your submission will be reviewed, and depending upon the answers, you may need to have an office visit prior to the Colonoscopy.**

Name \_\_\_\_\_ Phone #: \_\_\_\_\_ DOB: \_\_\_\_\_

1. Your Current Age is: \_\_\_\_\_

***Those who desire colon cancer screening below age 45 or above age 70 are encouraged to schedule an office visit to determine if screening is medically appropriate.***

2. What is your height (inches)? \_\_\_\_\_ What is your weight (lbs.)? \_\_\_\_\_

3. Do you have any gastrointestinal symptoms such as

- |                                     |                              |                             |
|-------------------------------------|------------------------------|-----------------------------|
| a. abdominal pain                   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b. bleeding                         | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c. weight loss                      | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d. difficulty swallowing            | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| e. frequent diarrhea                | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| f. personal history of Colon Cancer | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

4. 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, congestive heart failure | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c. stroke, seizure, or fainting spells  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d. renal failure or dialysis  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| e. sleep apnea or respiratory problems (COPD, emphysema, home oxygen or active asthma)                    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| f. defibrillator, pacemaker, or artificial heart valve  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| g. organ transplant other than cornea   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| h. diabetes   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| i. bleeding disorders   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

5. Do you experience chest pain or shortness of breath? Yes  No

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

7. Have you had a colonoscopy in the past? Yes  No

a. If YES:

i. Was this performed by Gastrointestinal Associates Yes  No

ii. Date of colonoscopy: \_\_\_\_\_

iii. Facility where completed: \_\_\_\_\_

iv. Physician performing colonoscopy: \_\_\_\_\_

v. Office phone number of physician (if not GIA): \_\_\_\_\_

**If the procedure was not done by Gastrointestinal Associates, we will need to obtain a copy of the procedure report and any biopsy results. You will need to sign a Medical Release for this.**

8. Do you have a family history of Colon Cancer or Polyps? Yes  No   
***If Yes, which relative had cancer or polyps and how old were they?***

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9. Are you taking any medications for High Blood Pressure? Yes  No

10. Do you currently smoke? Yes  No

11. How often do you drink alcohol: Never  Daily  Weekly  Monthly

12. Do you use any illicit drugs? Yes  No

13. Do you have any medication allergies? Yes  No  ***If Yes, please list.***

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14. Do you take any medications? Yes  No

***If yes, list all medications that you take including herbals and over the counter medications:***

| Medication Name | Medication Name |
|-----------------|-----------------|
|                 |                 |
|                 |                 |
|                 |                 |
|                 |                 |
|                 |                 |
|                 |                 |

15. Have you had difficulty with anesthesia other than nausea? Yes  No   
***If yes, describe the difficulty***

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16. Have you ever had Colon Surgery (NOT A COLONOSCOPY)? Yes  No   
***If yes, describe the surgery and the date you had it.***

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17. Have you had Joint Replacement Surgery in the last 3 months? Yes  No

18. Have you ever had any of the following surgeries?  
a. Obesity surgery Yes  No   
b. Appendectomy (appendix removal) Yes  No   
c. Cholecystectomy (gallbladder removal) Yes  No   
d. Hysterectomy Yes  No   
e. Cesarean section (C-section) Yes  No   
f. Tonsillectomy Yes  No   
g. Any other surgery: \_\_\_\_\_

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

20. Is there a physician with whom you prefer to be scheduled? Name: \_\_\_\_\_

21. Do you prefer a Male or Female physician? Male  Female  No Preference

**Please complete all pages of this form and fax or mail to:**

**Gastrointestinal Associates, Inc.  
OAC Processing  
1095 Rydal Road, Suite 100  
Jenkintown, PA 19046**

**Ph: 267.620.1100**

**Fax: 215.572.1279**

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**GASTROINTESTINAL**  
**ASSOCIATES, Inc.**

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*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 certify that I have answered all questions correctly and completely. I understand that answering any questions incorrectly may impact my health.
- 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 the risk, benefits and alternatives 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.

By signing below, I understand and agree to the above:

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Insurance Coverage

Please provide the details of the insurance you anticipate that you will use for this procedure. Please include all information, including plan name, that is noted on your card.

### Primary Insurance

Name of Insurance: \_\_\_\_\_

ID Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

### Secondary Insurance

Name of Insurance: \_\_\_\_\_

ID Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

**Please note:** If your insurance information changes after you are scheduled but before the procedure, it is imperative that you call our office to alert us to avoid potentially charges.

**HIPAA AUTHORIZATION FOR USE OR DISCLOSURE  
OF HEALTH INFORMATION**

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

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

I authorize the following using or disclosing party  
(list the facility where previous colonoscopy was completed):

\_\_\_\_\_

to use or disclose the following health information:

- All of my health information
- My health information relating to the following treatment or condition:

\_\_\_\_\_

The above party may disclose this health information to the following recipient:

Gastrointestinal Associates, Inc.  
1095 Rydal Road, Suite 100  
Jenkintown, PA 19046  
Ph: 267.620.1100  
Fax: 215.572.1279

I understand that this authorization will remain in effect until the provider fulfills this request.

I understand that I may revoke this authorization by sending notification, in writing, to the following:

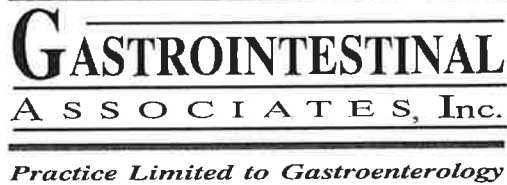
Alfreda Rawlings, Privacy Officer  
1095 Rydal Road, Suite 100  
Jenkintown, PA 19046

\_\_\_\_\_

Signature of Patient or Personal Representative

\_\_\_\_\_

Date



## 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 COLONOSCOPY 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.