Gastrointestinal Associates, Inc.

Open Access Colonoscopy Questionnaire

This form may be completed online at 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 ☐ No ☐
   b. bleeding — Yes ☐ No ☐
   c. weight loss — Yes ☐ No ☐
   d. difficulty swallowing — Yes ☐ No ☐
   e. frequent diarrhea — Yes ☐ No ☐
   f. personal history of Colon Cancer — Yes ☐ No ☐

4. Do you have or have been treated for any of the following?
   a. ulcerative colitis or Crohn's disease — Yes ☐ No ☐
   b. heart attack, irregular heartbeat, coronary artery bypass or stent placement, congestive heart failure — Yes ☐ No ☐
   c. stroke, seizure, or fainting spells — Yes ☐ No ☐
   d. renal failure or dialysis — Yes ☐ No ☐
   e. sleep apnea or respiratory problems (COPD, emphysema, home oxygen or active asthma) — Yes ☐ No ☐
   f. defibrillator, pacemaker, or artificial heart valve — Yes ☐ No ☐
   g. organ transplant other than cornea — Yes ☐ No ☐
   h. diabetes — Yes ☐ No ☐
   i. bleeding disorders — Yes ☐ No ☐

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?

____

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.***

____

14a. Do you take any prescription medications? Yes ☐ No ☐
If yes, please list all prescription medications that you take:

Prescription Medication Name

14b. Do you take any ***herbals and over the counter*** medications? Yes ☐ No ☐
If yes, please list all other medications that you take:

Vitamins, Herbals & OTC Medication Name

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

____

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

____

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: ____________________

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

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 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.