Doylestown Health
Gastroenterology

Open Access Colonoscopy: Patient Information

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Overview

Open Access Colonoscopy allows healthy patients, without exclusion criteria, to receive a screening colonoscopy without an initial office visit.

Colonoscopy screening is a test for early diagnosis of common cancers before symptoms develop.

Colorectal cancer is the second leading cause of cancer related deaths a 5-6 percent lifetime risk.

The current recommendation for colon cancer screening by the American Cancer Society is a colonoscopy starting at the age of 45*. Future examinations are planned based on the findings.

Exclusion criteria list includes:

- Anemia
- Anticoagulants (blood thinner) / Antiplatelets / clotting diathesis
- Multiple or unstable co-morbidities (having one or more additional diseases)
  - » Unstable cardiac disease, pacer/defibrilator, endocarditis, recent myocardial infarction (MI)
  - » O2 or steriod dependent pulmonary disease
  - » Renal distress, dialysis
  - » Neurologic disorders
- Chronic constipation requiring laxatives
- GI bleeding, change in bowel movements, weight loss, bleeding
- Chronic narcotic use for pain control
- Insulin dependent diabetes
- Previous problems with anesthesia
- Age > 80
- Overweight (BMI above 45)
- Chronic conditions (such as Crohn's disease and ulcerative colitis)

If a patient has any condition listed above, they will need to be seen by the GI physician in the office prior to the colonoscopy procedure.

To begin this process, please complete the questionnaire and registration forms and return mail or fax to:

Doylestown Health Gastroenterology
599 W State Street, Ste 200 | Doylestown, PA 18901
Phone: 215.345.6050 | Fax: 215.345.6568

Please allow several weeks for the paperwork to be processed.
Paperwork needs to be filled out in its entirety or it will not be processed.

*It is the patient's responsibly to confirm insurance coverage.

Questionnaire *(Form submission is good for 90 days)*

Patient Name: ______________________ **Date of Birth:** ____________

Phone (Day): ____________ **Phone (Cell):** ____________

Height: ____________ **Weight:** ____________

Primary Care Physician: ______________________

GI Symptoms:

- ☐ Poor appetite
- ☐ Weight loss
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Bleeding
- ☐ Nausea / vomiting
- ☐ Abdominal pain
- ☐ Change in bowel pattern
- ☐ Polyps / Diverticulosis
- ☐ None

Other Symptoms:

- ☐ Fever
- ☐ Chest pain
- ☐ Bleeding problems
- ☐ Lightheadedness / Fainting
- ☐ Breathing difficulties
- ☐ None

Past Medical History:

- ☐ Anemia
- ☐ Cancer
- ☐ Crohn's disease
- ☐ Diverticulitis
- ☐ Liver disease / Hepatitis
- ☐ Ulcerative colitis
- ☐ Polyps
- ☐ Lung problems
- ☐ Sleep apnea / CPAP use
- ☐ Diabetes
- ☐ Blood clotting problems
- ☐ Heart problems
- ☐ Hypertension
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Endocarditis Need for antibiotics before procedure
- ☐ Seizure
- ☐ Stroke
- ☐ DVT / PE
- ☐ MRSA or VRE
- ☐ TB (Tuberculosis)
- ☐ None

Previous Procedure / Surgical Information:

- ☐ EGD / Colonoscopy – Where: ____________ Date: ____________
- ☐ Gastric bypass / Abdominal surgery – Explain: ____________
- ☐ Previous surgeries (general, orthopedic, etc) – Explain: ____________

Medications: *Please attach list of medications, vitamins and aspirin products or blood thinners*

- ☐ Aspirin or aspirin products
- ☐ NSAID (Celebrex, ibuprofen, naproxen, Toradol, Lodine, Indocin)
- ☐ Vitamins
- ☐ Blood thinners (Plavix, Xarelto, Lovenox, Coumadin, Pradaxa, Eliquis)
- ☐ None
- ☐ Other ____________

Allergies: ______________________

Family History

- ☐ Colon cancer
- ☐ Polyps

Personal History

- ☐ Colon cancer
- ☐ Alcohol
- ☐ Polyps
- ☐ Tobacco

Established GI patients will see their current provider.

New patients will be scheduled first available procedure date.

Registration

Referring Physician: ______________________ Date: ______________

Patient Name: ______________________ Date of Birth: ______________

Phone: ______________ Email: ______________________

Address: ______________________________________

City: ______________ State: ______________ Zip: ______________

IMPORTANT NOTE

Your Open Access Registration Form will **NOT** be processed unless the paperwork is completely filled out **AND** accompanied by a copy of your current Insurance Card (Front and Back)

I authorize release of my medical information to the above named medical insurance company(ies) and their agents for the purpose of obtaining payment of services and determining insurance eligibility. I authorize payment of medical benefits to Doylestown Health Gastroenterology.
I understand that omitting or falsifying information about my health may lead to injury or could result in cancellation of my procedure.

Insurance ______________________ Policy #: ______________

Patient Signature ______________________ Date: ______________

Confidential Communication Permissions

I hereby give my permission for the release of my medical information to the following persons:

Name ______________________ Relationship: ______________

Name ______________________ Relationship: ______________

Name ______________________ Relationship: ______________

☐ I do not wish any medical information to be released. Initial: ____________

☐ I give permission to leave a detailed message on an answering machine or with a family member

Patient Signature ______________________ Date: ______________

Nondiscrimination Statement
Doylestown Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al +1.215.345.2200.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 +1.215.345.2200.