

Open Access Colonoscopy – Patient Information

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:

- Anticoagulants (blood thinner) / Antiplatelets / clotting diathesis
- Multiple or unstable co-morbidities (having one or more additional diseases)
 - Unstable cardiac disease, pacemaker/defibrillator, endocarditis, recent myocardial infarction (MI)
 - O2 or steroid 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)

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 responsibility to confirm insurance coverage.

Questionnaire

Patient Name: _____ Date of Birth: _____

Phone (Day): _____ Phone (Cell): _____

Height: _____ Weight: _____

Primary Care Physician: _____

GI Symptoms:

- | | | |
|--|--|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Polyps / Diverticulosis |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Nausea / vomiting | <input type="checkbox"/> None |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Abdominal pain | |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Change in bowel pattern | |

Other Symptoms:

- | | | |
|-------------------------------------|---|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Breathing difficulties |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Lightheadedness / Fainting | <input type="checkbox"/> None |

Past Medical History:

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

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*

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Aspirin or aspirin products | <input type="checkbox"/> Vitamins | <input type="checkbox"/> None |
| <input type="checkbox"/> NSAID (Celebrex, ibuprofen, naproxen, Toradol, Lodine, Indocin) | <input type="checkbox"/> Blood thinners (Plavix, Xarelto, Lovenox, Coumadin, Pradaxa, Eliquis) | <input type="checkbox"/> Other _____ |

Allergies: _____

Family History

- | | |
|---------------------------------------|---------------------------------|
| <input type="checkbox"/> Colon cancer | <input type="checkbox"/> Polyps |
|---------------------------------------|---------------------------------|

Personal History

- | | | |
|---------------------------------------|---------------------------------|----------------------------------|
| <input type="checkbox"/> Colon cancer | <input type="checkbox"/> Polyps | <input type="checkbox"/> Tobacco |
| <input type="checkbox"/> Alcohol | | |

Physician Requested:

- | | | |
|--|---|--|
| <input type="checkbox"/> Dr. Robert Akbari | <input type="checkbox"/> Dr. Hannah Do | <input type="checkbox"/> Dr. Louis Morsbach |
| <input type="checkbox"/> Dr. Christopher Bruce | <input type="checkbox"/> Dr. Robert Hale | <input type="checkbox"/> Dr. Sandhya Salguti |
| <input type="checkbox"/> Dr. Alan Chang | <input type="checkbox"/> Dr. Joseph Minissale | <input type="checkbox"/> Dr. Kiley Walp |

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: _____



Village Improvement Association of Doylestown
The Village Improvement Association of Doylestown (VIA) founded Doylestown Hospital, and today VIA members continue to oversee the governance of Doylestown Health. To learn more or become a member, visit VIA-Doylestown.org.

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.