Doylestown Health
Gastroenterology

Once you have completed the form and submitted it to our office, you will be contacted to review your eligibility. After this review, you should understand that you may not qualify to be scheduled through the Open Access program. If you do not meet the criteria, you will be asked to schedule an office visit.

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.

***It is the responsibility of the patient to confirm insurance coverage.**

Exclusion criteria list includes:

- Unexplained 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, unintended weight loss, bleeding
- Chronic narcotic use for pain control
- Insulin dependent diabetes
- Previous problems with anesthesia
- Age > 75
- Overweight (BMI above 45)
- Chronic conditions (such as Crohn's disease and ulcerative colitis)

If you have any condition listed above, you will be asked to schedule an office visit with one of our physicians prior to scheduling a colonoscopy.

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.

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

Patient Name: _____ **Date of Birth:** _____

Phone (Primary): _____ **Phone (Secondary):** _____

Height: _____ **Weight:** _____

Primary Care Physician: _____

GI Symptoms:

- ☐ Poor appetite
- ☐ Unintended weight loss
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Bleeding
- ☐ Nausea / vomiting
- ☐ Unexplained abdominal pain
- ☐ Change in bowel pattern
- ☐ Polyps / Diverticulosis
- ☐ Extensive abdominal surgery/ies
- ☐ Consistent urge for bowel movement that does not go away after bowel movement
- ☐ None

Other Symptoms:

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

Past Medical History: *Do you have any of the following or have you been treated for any of them in the past?*

- ☐ 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
- ☐ Endocarditis
  Need for antibiotics before procedure
- ☐ Kidney disease
- ☐ Seizure
- ☐ Stroke
- ☐ DVT / PE
- ☐ MRSA or VRE
- ☐ TB (Tuberculosis)
- ☐ None

Previous Procedure / Surgical Information:

- ☐ EGD / Colonoscopy – Where (attach prior report): _____ Date: _____
- ☐ Gastric bypass / Abdominal surgery – Explain: _____
- ☐ Previous surgeries (cardiac, lung, transplant, GI, 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 (not seasonal): _____

Personal History

- ☐ Colon cancer
- ☐ Alcohol
- ☐ Colon polyps
- ☐ Tobacco
- ☐ Positive Cologuard
  Date: _____

Family History (any first degree relatives)

- ☐ Colon cancer
- ☐ Colon polyps

Established GI patients will see their current provider.

New patients will be scheduled first available procedure date.

Registration

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)

IF YOUR INSURANCE REQUIRES A REFERRAL, IT IS YOUR RESPONSIBILTY TO OBTAIN ONE FROM YOUR PCP. RESCHEDULED PROCEDURES WILL REQUIRE A NEW REFERRAL.

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: _____

****If you have any changes to your health status or to your insurance after being scheduled, you will need to contact our office on 215.345.6050 x103. Your procedure may need to be rescheduled.**

Doylestown Health