GASTROENTEROLOGY MEDICAL ASSOCIATES, PA
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Colonoscopy Procedure Screening Form

Patient Information or Label:
Name: ______________________
DOB: ______________________
Address: ______________________
Phone: ______________________
Mobile: ______________________
Insurance Carrier: ______________________
Policy ID #: ______________________
Ht. ____________
Wt. ____________

Patients not fit for direct access should be referred to a GI specialist for assessment prior to colonoscopy.

Date of Call/Referral: _______/_______/_______

- **How did you hear about us?**
- **Reason for procedure:**

  O Asymptomatic person age 50 years and older
  O Asymptomatic person at high risk
  O Have you had a colonoscopy in the past?________Reason/findings ______________________
  (Most recent exam: _____/_____/_____ with Dr.__________________)

- **Medical History:** Circle "**yes**" or "**no**" for each item below. *If "**yes**" is selected for <u>any</u> of the items below, the patient is not a good candidate for direct screening colonoscopy. Refer to a GI specialist.*

Is the patient			Notes:
Age 65 or older?	Yes	No	
WHAT IS HEIGHT/WEIGHT	Yes	No	
Under treatment for heart failure or valve-related concerns?	Yes	No	
Under treatment for kidney disease?	Yes	No	
Under treatment for emphysema?	Yes	No	
On blood thinners?	Yes	No	
Under active treatment for a recent episode of diverticulitis?	Yes	No	
Pregnant or possibly pregnant?	Yes	No	
Does the patient have...			Notes:
Family history of colon cancer or cervical/uterine/ovarian cancer, stomach/esoph cancer?	Yes	No	
Heme (blood in stool) (+) stool, rectal bleeding, or iron deficiency anemia?	Yes	No	
A pacemaker or automatic implantable cardioverter defibrillator?	Yes	No	
Inflammatory Bowel Disease (Ulcerative Colitis or Crohn's Disease)?	Yes	No	
A history of severe cardiac/pulmonary/renal/hepatic disease requiring oxygen supplementation? Dialysis?	Yes	No	
A history of endocarditis, rheumatic fever, or stents?	Yes	No	
A history of difficult, incomplete, or poorly prepped colonoscopy?	Yes	No	
A history of difficulty with previous sedation/anesthesia?	Yes	No	
A history of Sleep Apnea?	Yes	No	
A history of Diabetes?	Yes	No	

- **Please provide the following:**
  1) Name of Primary Care Physician OR referring physician
  2) Updated medication list (including allergies)
  3) Updated problem list (including relevant medical/surgical history)
  4) Your most recent progress note (from physician) and labs
  5) Pharmacy name and phone number

- **Assessment: This patient is a good candidate for a direct referral for colonoscopy.** YES NO

Physician Signature: ________________________________

Physician Name (Print): HAROLD TEPLER, MD / JEFFREY RASKIN, MD