Direct Access Colonoscopy Questionnaire

Sripathi Kethu, M.D.

Patient Name: ____ Today's Date: ____________________

Patient Phone Number: ________________________________ Sex: ☐ Male ☐ Female

YES	NO	STOP * **Absolute Contraindications to Scheduling Direct Access Colonoscopy at ASC/Endo Centers**
☐	☐	Do you have an Internal Cardiac Device/Pacemaker/Defibrillator?
☐	☐	Have you had a myocardial infarction and/or stent placement within **6 months?**
☐	☐	Have you had an Organ Transplant or are you currently on a waiting list?
☐	☐	Are you on dialysis?
☐	☐	Do you use Oxygen?
☐	☐	Any chance you could be pregnant?
		How tall are you? Height_________ And how much do you weigh? Weight ___________

BMI: _______________ If BMI > 45, Consult Endoscopy Center Nursing Director; If BMI > 50, STOP*

Patient should be scheduled for a New Patient Office Visit

YES	NO	
☐	☐	Have you seen or are you under the care of a cardiologist?
☐	☐	History of MI, arrhythmia, bypass or Heart Valve Replacement, Angioplasty/Stents. If yes, when? ____________________________________? **Notify patient Cardiac Clearance is required.**
☐	☐	Stroke, Blood disorders, bleeding problems, circulatory problems, lower extremity edema.
☐	☐	Asthma, breathing problems, emphysema, COPD or lung surgery, or use a CPAP machine?
☐	☐	Kidney failure, kidney disease?
		MEDICATIONS – If Yes to any of the below, SEE ADDITIONAL INFORMATION
☐	☐	Aspirin products or blood thinners such as Coumadin, Warfarin, Plavix, Lovenox?
☐	☐	Do you have high blood pressure or hypertension? On Medication?
☐	☐	Do you have, or have you had Seizures or Anxiety? On Medication?
☐	☐	Diabetes, Type I or Type II – On Medication?
☐	☐	Previous colonoscopy. If Yes, When and Why? ____
☐	☐	*Personal* history of colon polyps or colon cancer; if yes, please circle which history applies
☐	☐	*Family* history of colon polyps or colon cancer; if yes, please circle which history applies
☐	☐	Previous Anesthesia Complications?

Proceed with Direct Access Scheduling:

Address: ____

City ____ State ___________________ Zip __________________

Patient E-mail Address: ____

Health Plan Name: ____ Date of Birth: _____________________

DHAT Physician Name: ______________________________________ Procedure Date: ________________________

Endo Center: ____

❒ Mail Paperwork to Home Address ❒ Email Paperwork to above Email Address

☐ **Cardiac clearance requested by _________________________________ on _____________________________.**

DHAT Employee: ____ ❒ Scanned into eCW Acct#: ______________

I have reviewed the above patient history and agree that this patient is an appropriate candidate for Direct Access Colonoscopy Scheduling.

Reviewed by DHAT Physician: ____