

IF YOU WOULD LIKE TO BE CONSIDERED FOR AN EASY-ACCESS COLONOSCOPY, COMPLETE THIS ENTIRE PACKET, AND RETURN IT TO MILE BLUFF FOR REVIEW.



Return the enclosed paperwork one of three ways:

- **in person:** at the medical center or any of Mile Bluff's clinics
- **through the mail:** Mile Bluff Clinic; Attn: West Pod; 1040 Division Street; Mauston, WI 53948
- **by Fax:** 608-847-9752

If you are not contacted within 14 business days of returning your paperwork, please call 608-847-5000.

PATIENT INFORMATION - SCREENING COLONOSCOPY

WHAT IS A COLONOSCOPY? It is procedure that uses a flexible tube (colonoscope) with a camera, to access and view the inside of the large intestines. During the procedure, tissue samples (biopsies) can be taken, and abnormal growths (such as polyps) can be removed. On average, the procedure takes 20 minutes to an hour. During this time, patients are given medication through an IV to stay sleepy/asleep.

WHY IS A COLONOSCOPY NEEDED? It is the recommended way to detect colon cancer and/or pre-cancerous polyps. It can also be used to evaluate symptoms such as rectal bleeding, diarrhea, changes in bowel habits, etc. Colonoscopies are especially recommended for those who have an increased risk of colon cancer due to family history of colon cancer or personal history of inflammatory bowel disease.

WHAT IS AN EASY-ACCESS COLONOSCOPY? It is a screening colonoscopy that doesn't require the usual clinic visit before the procedure.

WHO IS ELIGIBLE FOR AN EASY-ACCESS COLONOSCOPY? This is an option for healthy, age-appropriate patients who have minimal safety risks. To be considered, applicants must complete and return this entire packet for review. If it is determined to be safer for a patient to undergo a traditional colonoscopy, a clinic visit with a provider will be scheduled.

WHAT IS EXPECTED AFTER THE PROCEDURE? Patients may feel bloated or have cramping for one to two hours after a colonoscopy; and some may be tired and need to nap. It is also common to go a day or two without a bowel movement. Patients are encouraged to eat only a light meal after the procedure, and then return to a normal diet once they feel up to it. If a biopsy was done or polyps were removed, there may be a small amount of bleeding from the rectum. Patients generally recover and return to usual activities the day after the procedure.

HOW SUCCESSFUL IS A COLONOSCOPY? In most patients, the entire colon can be examined during the procedure. There are times a polyp or other abnormality is not seen - this risk increases when colonoscopy preparation isn't completed according to instructions. In addition, abnormalities in a person's colon can occasionally make a complete exam impossible. In these cases, additional testing may be needed, such as a barium enema X-ray or CT colonography (virtual colonoscopy), or another colonoscopy procedure.

WHAT ARE THE ALTERNATIVES TO A COLONOSCOPY? There are several other methods which can be used to examine a patient's bowels. A limited examination looks only at the rectum and lowest portion of the colon (flexible sigmoidoscopy). There is also the barium enema X-ray and CT colonography (virtual colonoscopy). In addition, there is the option to have a patient's stool screened for the presence of small amounts of blood.

WHAT ARE THE RISKS OF A COLONOSCOPY? A colonoscopy is considered to be safe. However, as with any procedure, there are risks. Complications include infection, puncture or tear of the bowel wall, bleeding, cardiac problems or rhythm disturbances, sedation-related complications, and even death - which is very rare. Overall, complications only occur in about 1 out of every 1000 patients (0.1%).



1040 Division Street | Mauston, Wisconsin 53948
608-847-5000 | milebluff.com

Healthcare evolving for life

EASY-ACCESS COLONOSCOPY APPLICATION

Last name: _____ First name: _____ MI: _____

Birthdate: ____ / ____ / ____ Gender: _____ Primary language: _____

Race (*Federal requirement*): _____ Ethnicity: Hispanic or Latino non-Hispanic or non-Latino

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____

Cell phone: (____) - ____ - ____ Home phone (*if applicable*): (____) - ____ - ____

Best time to call: morning afternoon any time

If we are not able to reach you, can we leave a message? yes no

If yes, check all that apply:

You can leave a message on my voicemail.

___ Please only leave a basic message asking me to call the clinic.

___ You can leave a detailed message.

You can leave a message with someone else who answers the phone.

___ Please only leave a basic message asking me to call the clinic.

___ You can leave a detailed message.

Marital status: single married other Student status: full-time part-time NA

Employment status: full-time part-time other

Employer (*if applicable*): _____ Occupation: _____

Emergency contact name: _____ Relationship to you: _____

Emergency contact phone: (____) - ____ - ____

Preferred pharmacy: _____ Phone: (____) - ____ - ____

Pharmacy address: _____ Fax: (____) - ____ - ____

Name of provider who referred you for a colonoscopy: _____

Provider's organization: _____ Phone: (____) - ____ - ____

Address: _____

COLONOSCOPY QUESTIONNAIRE

Name: _____

Birthdate: ____ / ____ / ____ Age: _____ Height: _____ Weight: _____

1. Have you had a colonoscopy in the past? yes no
 - a. If yes, when and where? _____
 - b. What were the results? _____
2. Why are you requesting a colonoscopy? _____
3. Do you have a family history of colon cancer and/or polyps? yes no
 - a. If yes, list relative(s) (mom, uncle, grandfather, sister, etc.) and age(s) diagnosed _____

4. Do you have any gastrointestinal symptoms such as abdominal pain, bleeding, weight loss, diarrhea, constipation or anemia? yes no
5. Have you ever had any of the following:
 - a. Ulcerative colitis or Crohn's disease yes no
 - b. Heart attack, irregular heartbeat, coronary artery bypass or stent placement, stroke, seizure, fainting spells, congestive heart failure yes no
 - c. Renal failure or dialysis yes no
 - d. Respiratory problems (COPD, emphysema, home oxygen, asthma) yes no
 - e. Diabetes yes no
 - f. Sleep apnea yes no
 - g. Defibrillator, pacemaker or artificial heart valve yes no
 - h. Organ transplant (other than cornea) yes no
 - i. Blood disorders (such as hemophilia) yes no
6. Do you have MRSA (Methicillin-Resistant Staphylococcus Aureus)? yes no
7. Have you had a joint replacement? yes no
8. Do you smoke? yes no
 - a. If yes, how often and how much? _____
9. Do you take any of these blood-thinning medications daily? yes no
If yes, check all that apply.

<input type="checkbox"/> Coumadin (warfarin)	<input type="checkbox"/> Lovenox (enoxaparin)	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Pradaxa (dabigatan)
<input type="checkbox"/> Trental (pentoxifylline)	<input type="checkbox"/> Plavix (clopidogrel)	<input type="checkbox"/> Eliquis (apixaban)	<input type="checkbox"/> Xarelto (rivaroxaban)
<input type="checkbox"/> Savaysa (edoxaban)	<input type="checkbox"/> Betrixaban (bevyxxa)	<input type="checkbox"/> Prasugrel (effient)	<input type="checkbox"/> Ticagrelor (brilinta)
<input type="checkbox"/> Fondaparinux (arixtra)	<input type="checkbox"/> Other _____		
10. Do you have bleeding problems? yes no

11. Do you have an allergy to latex? yes no

12. Do you have any allergies to medications or to eggs? yes no

If yes, please list: _____

13. List all medications that you take, including herbal supplements and other over-the-counter medications:

14. Have you had difficulty with anesthesia other than nausea? yes no

15. Are you able to walk without assistance? yes no

INSURANCE INFORMATION

Primary insurance company: _____

Phone: (_____) - _____ - _____ Policy holder name: _____

Your relationship to policy holder: self spouse child other

Insurance ID number: _____ Group number: _____

Secondary insurance company (if applicable): _____

Phone: (_____) - _____ - _____ Policy holder name: _____

Your relationship to policy holder: self spouse child other

Insurance ID number: _____ Group number: _____

****Please include a copy of the front and back of your current insurance card(s).****

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE THIS INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION, HEALTHCARE FINANCING ADMINISTRATION, MY INSURANCE COMPANY OR ITS INTERMEDIARIES/CARRIERS, OR TO THIS PHYSICIAN'S OFFICE, MY ATTORNEY OR OTHER DOCTOR'S OFFICE.

I AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS AND/OR SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE, AND ANY OTHER HEALTH PLAN. I ALSO PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. THIS ASSESSMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE.

Patient signature: _____ Date: ____/____/____

Patient name (printed): _____

ACKNOWLEDGEMENT OF UNDERSTANDING

By signing below, I acknowledge that I understand the following:

- An easy-access colonoscopy is designed for healthy, age-appropriate patients to have a screening colonoscopy without the need for an office visit before the procedure.
- The questionnaire I completed will be carefully reviewed, and I may be called to clarify my answers.
- After review, and with my safety in mind, a decision will be made about whether I can be scheduled for an easy-access colonoscopy, or if I will need to schedule an office visit before my procedure.
- If I am scheduled for an easy-access colonoscopy:
 - I will not receive a gastrointestinal (GI) consultation before the procedure. I confirm that this is my decision, and that I have declined my opportunity to make an appointment for an office visit to discuss my colonoscopy.
 - If I want to have any GI complaints addressed, I will have to make a separate office visit to discuss them.
 - The instructions for the procedure's preparation, process and recovery will be given to me over the phone.
 - I must read, understand and comply with the instructions I am given.
 - I will receive a brief physical exam on the morning of the procedure.
- While complications are not likely, the risks of the procedure have been outlined for me. I have reviewed them, and understand the risks.
- If after my colonoscopy is schedule, there are changes in my health status or insurance, I will call 608-847-5000.
- I must have someone drive me home after my colonoscopy. **Without a driver in attendance on the day of my procedure, my colonoscopy will be canceled.**
- I will be called with my biopsy results, which could result in the need for a follow-up clinic appointment.

Patient signature: _____ **Date:** ____ / ____ / ____

Patient name (printed): _____