

Audubon GI Associates

Noel D. Canlas, MD ♦ Karen R. Canlas, MD
1413 N. Elm Street, Henderson, KY 42420
Phone # 270-826-0002

Dear Patient:

Your physician has requested that you undergo an outpatient screening colonoscopy. The

American Cancer Society and the American Gastroenterological Association both recommended screening for colon polyps and colon cancer in those 50 years of age or older. If you have a family history of colon cancer, you may require evaluation earlier.

Colonoscopy is performed to identify and remove precancerous polyps. If you have any gastrointestinal complaints such as rectal bleeding, chronic abdominal pain, or a change in bowel habit, it may be necessary for you to be seen in our clinic for evaluation before scheduling a procedure.

To begin the process of scheduling a screening colonoscopy, please fill out and return the following to our office at the address above or in the mail with the pre-addressed envelope provided or via fax at (270) 826-0003:

- (1) Colonoscopy Scheduling Form
- (2) Patient Information Form
- (3) Patient Registration Form and Insurance Form
- (4) A copy of both sides of your medical insurance card

After your forms are reviewed by our office, you will receive a phone call from our staff to schedule your colonoscopy or, if needed, an office consultation. If you have any questions or concerns about this process, please do not hesitate to call our office at (270) 826-0002. Thank you for allowing us to participate in your health care.

Sincerely,

Noel D. Canlas, MD

Karen R. Canlas, MD

Audubon GI Associates

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COLONOSCOPY SCHEDULING FORM

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

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Family/Referring Physician: _____

PATIENT INFORMATION FORM

Patient Name: _____

Age: _____

Are you having any GI symptoms? _____

Do you have any of the following symptoms? (please circle all that apply)

Blood on wiping or in stool	Abdominal pain	Weight loss
Diarrhea	Constipation	Change in bowel habits
Reflux	Nausea	Vomiting
Vomiting blood	Black/tarry stools	Difficulty swallowing

Past Medical History:

Do you have or have you had any of the following? (please check)

	Yes	No		Yes	No
Asthma			Prosthetic joint replacement		
Anemia			Lung disease		
Bleeding problems			Emphysema/COPD		
Diabetes			Tuberculosis		
Cancer (if yes, see below)			Cirrhosis/Liver disease		
High blood pressure			Kidney failure/disease		
Heart disease/attack			Dialysis		
Stroke			Stomach ulcer		
Heart murmurs			Heartburn/reflux		
Heart arrhythmias			Hiatal hernia		
Angina/chest pain			Colon problems (if yes, see below)		
Artificial heart valve					
Endocarditis			Depression/anxiety		
Rheumatic fever			Psychiatric disorders		
Seizures			Neurologic disorders		

If yes to questions above:

What type of cancer? _____

What type of colon problems? _____

Any additional medical history? _____

Please list all prior surgeries and approximate dates:

Year	Type/Reason for surgery

PATIENT INFORMATION FORM

Do you use tobacco? Yes No
If yes, how much? _____

Do you use alcohol or beer? Yes No
If yes, how much and how often? _____

Do you use any illegal drugs? Yes No
If yes, what and how often? _____

Please list any Drug Allergies:

Please list all medications (include herbals, vitamins, over-the-counter medications):

Medication	Strength	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have a family history of cancer; especially colon, ovarian, uterine or breast cancers?

Yes No

If yes, who and what age were they diagnosed? _____

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PATIENT REGISTRATION FORM

Patient Name	Date of Birth	Age	Social Security No.	Marital Status
Address	City, State, Zip		Phone	Account #
Employer	Employer Address		City, State, Zip	
Spouse/Parent/Guardian	Date of Birth		Relation to Patient	
Spouse/Parent/Guardian Address	City, State, Zip	Phone	Work Phone	
Spouse/Parent/Guardian Employer	Employer Address		City, State, Zip	
Emergency Contact	Relation to Patient	Home Phone	Work Phone	
Referring Physician	Primary Care Physician			

INSURANCE INFORMATION

Primary Insurance	ID Number	Group Number	Phone
Insurance Address	City, State, Zip		Effective Date
Name of Insured	Date of Birth	Employer of Insured	Relation to Patient
Secondary Insurance	ID Number	Group Number	Phone
Insurance Address	City, State, Zip		Effective Date
Name of Insured	Date of Birth	Employer	Relation to Patient

For Your Information:

Because you will be sedated, you will not be able to drive after your colonoscopy. You must arrange for a responsible adult (over 18) who can drive or otherwise accompany you to and from the hospital endoscopy unit. If you do not make these arrangements, notify us or your procedure may be re-scheduled or cancelled.

Side Effects and Risks of Colonoscopy

Along with the benefits of Colonoscopy, we must also inform you of the risks, although rare. While colonoscopy is an outpatient procedure, it is an endoscopic procedure performed in the hospital and certain risks are inherent to the procedure. You will be able to discuss the risks below with the physician on the day of your colonoscopy. A detailed informed consent will be discussed with you on the day of your procedure and you will be required to sign the consent form to undergo colonoscopy.

Bloating and abdominal distention are the most common side effects of the procedure and typically last for about one hour after the exam. Other risks of colonoscopy are minimal and less than 1%. They include, bleeding, infection, adverse reactions to sedation, perforation, and inpatient hospital admission due to any of these reasons. Quite uncommonly (in about 2% of cases), diagnostic oversight may occur.

If you have any questions or concerns, you may call our office and speak with the nurse. Again, you will be able to speak with the physician on the day of your procedure prior to the procedure being started.