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 50. Future examinations are planned based on the findings.

Open Access Colonoscopy allows healthy patients, without Exclusion Criteria, to receive a screening colonoscopy without an initial office visit.

Exclusion of…

- Anticoagulants (Blood Thinner) / Antiplatelets / Clotting diathesis
- Multiple or unstable co morbidities
  - Unstable Cardiac Disease, Pacer/Defibrilator, Endocarditis, Recent MI
  - O2 or steroid dependent pulmonary disease, sleep apnea or CPAP
  - Renal Distress, Dialysis
  - Neurologic disorders
- Extensive Abdominal Surgery
- GI bleeding, change in bowel movements, weight loss, bleeding
- Chronic narcotic use for pain control
- Insulin Dependent Diabetes
- Previous problems with Anesthesia
- Age > 80
- Overweight

To Initiate this process, please complete the Questionnaire and Registration forms and return by fax or mail to:

<table>
<thead>
<tr>
<th>Central Bucks Specialists, Ltd.</th>
<th>Fax Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Access</td>
<td>VIA Affiliates</td>
</tr>
<tr>
<td>599 W State Street, Ste 200</td>
<td>Open Access</td>
</tr>
<tr>
<td>Doylestown, PA 18901</td>
<td>Doylestown, PA 18901</td>
</tr>
<tr>
<td>or</td>
<td>Fax: 215-345-6568</td>
</tr>
<tr>
<td>Fax: 215-345-6568</td>
<td></td>
</tr>
</tbody>
</table>

Please allow two weeks for the paperwork to be processed. Paperwork needs to be filled out in its entirety or it will not be processed.
Patient Name:____________________________________________DOB:_______________________________________________
Best Daytime Phone #:_____________________________Cell #:__________________________Home#________________________
Primary Care Physician:_________________________________________________________________________________________

GI Symptoms: please check all that apply
○ Poor Appetite ○ Nausea / vomiting ○ Abdominal pain
○ Weight loss ○ Difficulty swallowing ○ change in bowel pattern
○ Heartburn ○ Polyps / Diverticulosis ○ Bleeding ○ None

Height: _______________ Weight: _______________

Past Medical History: please check all that apply
○ Anemia ○ Diabetes ○ DVT / PE
○ Cancer ○ Blood clotting problems ○ MRSA or VRE
○ Crohn's disease ○ Heart problems ○ TB (Tuberculosis)
○ Diverticulitis ○ Hypertension ○ None
○ Liver Disease / Hepatitis ○ High Cholesterol
○ Ulcerative colitis ○ Kidney Disease
○ Polyps ○ Seizure
○ Lung problems ○ Stroke
○ Sleep Apnea / CPAP use ○ Endocarditis - need for antibiotics before procedure

Previous Procedure Information:
○ Prior EGD / Colonoscopy - Where:__________________________________Procedure Date:____________________
  ○ List health issues since last colonoscopy:

Past Surgical History:
○ Gastric Bypass / Abdominal Surgery (please explain below)
Previous surgery's (general, orthopedic, etc): please explain
________________________________________________________________________________________________________________________________________

Medications: Please attach list of medications, vitamins and aspirin products or blood thinners:
○ aspirin or aspirin products ○ Lovenox
○ vitamins ○ coumadin (warfarin)
○ Plavix ○ Pradaxa
○ Xarelto ○ NSAID (Celebrex, ibuprofen, naproxen, Toradol, Lodine, Indocin)
○ Other________________________ ○ Eliquis
○ None

Please list all other medications:_________________________________________________________________________________

Please List any Allergies:_____________________________________________________________________________________

Family Medical History: please check if applies Colon Cancer________Polyps________

Social History: please check if applies Alcohol________Tobacco________

Review of Symptoms:
○ Fever ○ Lightheadedness / Fainting
○ Chest Pain ○ Breathing Difficulties
○ Bleeding Problems ○ None

Physician Requested
□ Dr. Robert Hale □ Dr. Sandhya Salguti
□ Dr. Joseph Minissale □ Dr. Victor Araya
□ Dr. Louis Morsbach □ Dr. Kiley Walp
□ Dr. Alan Chang □ None

Please allow two weeks for the paperwork to be processed.
Paperwork needs to be filled out in its entirety or it will not be processed.
Referring (Ordering) Physicians:_____________________________  Date:________________________
Patient Name:___________________________________________ DOB:________________________
Daytime Phone #:____________________________ Cell #:_____________________________________
E-Mail______________________________________________________________________________________________________________
Address:______________________________________________________________________________
City:___________________________ State:______________ Zip:_________________________

Please Fax Insurance Card with Form (Front/Back)

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)

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 Central Bucks Specialists, Ltd. I understand that omitting or falsifying information about my health may lead to injury or could result in cancellation of my procedure.

__________________________________________
Signature of Patient Date

CONFIDENTIAL COMMUNICATION PERMISSION FORM

With the new HIPAA Laws in effect as of April 15, 2003, I hereby give my permission for the release of my medical information to the follow persons:
NAME: __________________________________________ RELATIONSHIP: _____________________________
__________________________________________________________________________________________________________
__________________________________________________________________________________________________________
I do not wish any medical information to be released __________________________________
Please Initial

I also give Central Bucks Specialists, Ltd. permission to leave a detailed message on an answering machine or with a family member: YES NO

__________________________________________
Signature of Patient Date

__________________________________________
Central Bucks Specialists, Ltd  599 W State Street Ste 200  Doylestown, PA  18901    fax:215-345-6568
Brief History and Physical

Distribute Patient Questionnaire / Registration form - patient must complete and return to CBS

Review…
- Colonoscopy Procedure - brief review
- Anesthesia - please advise patient they must have a ride home
- Bowel preps - Several available - may require drinking up to 4 liters
- Procedure and anesthesia - required to have a ride home

Risks…
- Bleeding < 1%
- Reaction to medicine - Rare
- Perforation; < 1 in 3,000

Exclusion of…
- Anticoagulants / Antiplatelets / Clotting diathesis
- Multiple or unstable co morbidities
  - Unstable Cardiac Disease, Pacer/Defibrilator, Endocarditis, Recent MI
  - O2 or steroid dependent pulmonary disease, sleep apnea or CPAP
  - Renal Distress, Dialysis
  - Neurologic disorders
  - Psychiatric disorders
- Extensive Abdominal Surgery
- GI bleeding, change in bowel movements, weight loss, bleeding
- Chronic narcotic use for pain control
- Previous problems with Anesthesia
- Age > 80, BMI > 35

Physician Requested -
- Dr. Robert Hale
- Dr. Joseph Minissale
- Dr. Louis Morsbach
- Dr. Alan Chang
- Dr. Sandhya Salguti
- Dr. Stanley Hsu
- None