

Open Access Program: Colon Cancer Screening

Colon cancer screening made simple: If you are 45+, HVG's Open Access Program eliminates the initial office visit, making it easier than ever to schedule your colonoscopy.

How do I sign up?

To get started, please call our office to register and update your insurance information. Following that, fill out the attached assessment form. Please arrange for your primary care doctor to send a referral, recent visit notes and lab results.

Our experienced staff will review all of your information to determine if the open-access program is the best option for you. If approved, we will proceed with scheduling your procedure.

Now what?

Once your procedure is scheduled, HVG will send you your confirmed appointment information and detailed preparation instructions. Please read the instructions carefully to ensure full compliance. If you have any questions, please call 1-845-331-8222 or visit www.hvgpc.com.

You will meet with your physician immediately before the procedure. Following the colonoscopy, the doctor will discuss the findings with you, and a full report with follow-up recommendations will be sent to your referring physician and available on the HVG Patient portal.

What if HVG's Open Access Program is not for me?

If HVG's Open Access Program is not the best option for you, we are here to help. Our dedicated team will work closely with you to explore alternative approaches to ensure you get the care you need. Patients with the following conditions may be advised to schedule an office visit before scheduling a procedure

- Underlying abdominal pain, changes in bowel habits or any other gastrointestinal symptoms
- Significant illnesses (poorly controlled diabetes, significant cardiac disease, severe breathing problems, kidney problems)
- Rectal Bleeding
- Blood in stool or black tarry stools
- Positive Hemocult, FIT Test or Cologuard Test
- Weight Loss
- Anemia
- Patients less than 45 or over 75 years of age

OPEN ACCESS PROGRAM - Assessment Form

PATIENT NAME: _____ DOB: ____/____/____

DATE: ____/____/____ WEIGHT: _____ HEIGHT: _____

Do you have any known allergies or sensitivities including those to metals? Please list reactions.

Primary Care Physician: _____

Prior Colon Cancer screening: YES or NO

Date of Last Colonoscopy: _____ Date of Last FIT Test: _____ POS or NEG

Date of Last Cologuard: _____ POS or NEG Date of Last Guaiac: _____ POS or NEG

Personal History of Colon Polyps: YES NO

Personal History of Colon Cancer: YES NO

Family or Personal History of Anesthesia Complications: YES or NO In Whom? _____

Family History of Colon Cancer? YES NO In Whom? _____

Tobacco Use? YES NO FORMER If yes, how many per day? _____

Alcohol Use? YES NO FORMER If yes, how many per day? _____

Illicit Drug Use? YES NO If yes: Past or Present

Have you had any surgeries or procedures that required anesthesia in the past? What, when, and were there any complications to the anesthesia? _____

Do you have any Advanced Directives? _____

Do you have a Health Care Proxy? If yes provide name and relationship _____

Please list any medical problems below.

Do you use any assistive devices? (example: glasses, cane, walker, hearing aids)

Please list all current medications with dosage including over the counter medications

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you exercise regularly? YES NO If yes, describe: _____

Would you have difficulty walking 5 blocks or climbing 2 flights of stairs? YES NO
If yes, why? _____

Do you wake at night with shortness of breath or do you have to sleep sitting upright? YES NO
If yes, why? _____

Heavy Snoring / Frequent Nighttime Waking? YES NO

Do you have sleep apnea or use a CPAP? YES NO

Respiratory Problems (Emphysema, Asthma, Pneumonia) YES NO _____

Angina / Cardiac Chest Pain / Congestive Heart Failure / Heart Attack? YES NO _____

Atrial Fibrillation? YES NO

Heart Attack or Stroke in the past 2 months? YES NO

Heart Stent placed in the past 12 months? YES NO

Heart Problems that you get antibiotics before surgery? YES NO

Cardiac Pacemaker / Defibrillator? YES NO

Palpitations / Fainting? YES NO _____

Do you have high blood pressure? YES NO _____

Prosthetic Device / Implants / Heart Valve Defects / Heart Murmur? YES NO _____

Neurological Problems? YES NO _____

Seizures / Strokes / "Ministrokes" / Blackouts? YES NO _____

Leg Cramps / Pain with Exertion? YES NO _____

Abnormal Bleeding / Bruising Disorder? YES NO _____

Anemia? YES NO If yes: Past or Present _____

Gastroenterologist Problems? YES NO _____

Kidney / Urinary Problems / Dialysis? YES NO _____

Liver Problems (Cirrhosis / Hepatitis) YES NO _____

Diabetes? YES NO If yes: How long? _____ Insulin or Oral Medications? _____

Thyroid Problems? YES NO _____

Arthritis? YES NO _____

Muscle / Bone Disorders? YES NO _____

Joint Replacement in the past year requiring antibiotics before surgery? YES NO _____

Limited Neck Range/Motion or Mouth Opening? YES NO _____

Ear, Nose or Throat Problems? YES NO _____

Dentures (Full or Partial) or Removable Hardware in Mouth? YES NO _____

Cancer or Immune System Problems? YES NO _____

Psychiatric Problems? YES NO _____

Could you be pregnant? YES NO _____

Date of Last Menstrual Cycle? _____

FAMILY HISTORY

Please circle all that apply:

FATHER

High Blood Pressure
Heart Disease
Stroke
Liver Disease

Sickle Cell Anemia
Gallstones
Colon Polyps
Colon Cancer

Other:
Deceased? Cause:
Diabetes
Other Cancer:

MOTHER

High Blood Pressure
Heart Disease
Stroke
Liver Disease

Sickle Cell Anemia
Gallstones
Colon Polyps
Colon Cancer

Other:
Deceased? Cause:
Diabetes
Other Cancer:

NUMBER OF SIBLINGS:

High Blood Pressure
Heart Disease
Stroke
Liver Disease

Sickle Cell Anemia
Gallstones
Colon Polyps
Colon Cancer

Other:
Deceased? Cause:
Diabetes
Other Cancer:

NUMBER OF CHILDREN:

High Blood Pressure
Heart Disease
Stroke
Liver Disease

Sickle Cell Anemia
Gallstones
Colon Polyps
Colon Cancer

Other:
Deceased? Cause:
Diabetes
Other Cancer:

SOCIAL HISTORY

Marital Status: Single ___ Married ___ Widowed ___ Divorced ___ Domestic Partner ___
Legally Separated ___

Religious Preferences: _____

Work Status: Full Time ___ Part Time ___ Retired ___ Unemployed ___ Disabled ___

Occupation: _____

Smoking Tobacco: Yes ___ No ___ Former ___ If yes, how much per week? _____

Electronic Smoking (Vaping): Yes ___ No ___ If yes, how much per week? _____

Recreational/ Illegal Drug Use: Yes ___ No ___ If yes, please specify/when: _____

Alcohol Consumption: Yes ___ No ___ If yes, how much per week? _____

Do you have any piercings? Yes ___ No ___ If yes, where? _____

Do you have any tattoos? Yes ___ No ___ If yes, was it done with lead ink? Yes ___ No ___

Have you traveled out of the country recently? Yes ___ No ___ If yes, where and when? _____

CONSTITUTION

Yes ___ No ___ Decreased Appetite
Yes ___ No ___ Fatigue
Yes ___ No ___ Fever
Yes ___ No ___ Weight Loss
Yes ___ No ___ Weight Gain

EYES

Yes ___ No ___ Cataracts
Yes ___ No ___ Glaucoma
Yes ___ No ___ Corrective Lenses

ENMT

Yes ___ No ___ Hearing Loss
Yes ___ No ___ Seasonal Allergies
Yes ___ No ___ Congestion
Yes ___ No ___ Nose Bleeding
Yes ___ No ___ Septal Deviation, Nasal
Yes ___ No ___ Bleeding Gums
Yes ___ No ___ Chronic Cough
Yes ___ No ___ Dental Problems
Yes ___ No ___ Hoarse/Voice Changes
Yes ___ No ___ Hemoptysis - Coughing Up Blood
Yes ___ No ___ Mouth Sores
Yes ___ No ___ Thrush

RESPIRATORY

Yes ___ No ___ Asthma
Yes ___ No ___ Difficulty Breathing
Yes ___ No ___ COPD - Emphysema
Yes ___ No ___ History of Lung Blood Clots
Yes ___ No ___ Snoring
Yes ___ No ___ Pneumonia
Yes ___ No ___ Sleep Apnea

MUSCULAR

Yes ___ No ___ Arthritis
Yes ___ No ___ Fibromyalgia
Yes ___ No ___ Osteoporosis

SKIN

Yes ___ No ___ Bruising
Yes ___ No ___ Skin Cancer
Yes ___ No ___ Piercings
Yes ___ No ___ Psoriasis
Yes ___ No ___ Reynaud's
Yes ___ No ___ Tattoos with Lead Ink

BREAST

Yes ___ No ___ Cancer

Yes ___ No ___ TMJ Jaw Discomfort

HEART

- Yes ___ No ___ Angina, Chest Pain
- Yes ___ No ___ Arrhythmia
- Yes ___ No ___ Automatic Defibrillator
- Yes ___ No ___ CHF Congestive Heart Failure
- Yes ___ No ___ Congenital Heart Failure
- Yes ___ No ___ DVT Vein Thrombosis/Clots
- Yes ___ No ___ High Cholesterol
- Yes ___ No ___ High Blood Pressure
- Yes ___ No ___ MI - Heart Attack
- Yes ___ No ___ Pacemaker
- Yes ___ No ___ Blood Vessel Disease

NEURO

- Yes ___ No ___ CVA, Stroke
- Yes ___ No ___ Headache
- Yes ___ No ___ Memory Loss
- Yes ___ No ___ Parkinson's Disease
- Yes ___ No ___ Restless Leg Syndrome
- Yes ___ No ___ Seizures
- Yes ___ No ___ TIA's Mini Strokes

PSYCH

- Yes ___ No ___ Anxiety
- Yes ___ No ___ Eating Disorder
- Yes ___ No ___ Depression
- Other: _____

HOW DID YOU HEAR ABOUT US?

- ___ MD Referral
- ___ Newspaper
- ___ Phonebook
- ___ Internet
- ___ Family/Friend
- ___ Other

ENDOCRINE

- Yes ___ No ___ Diabetes 1 OR 2 (Circle)
- Yes ___ No ___ Kidney Disease
- Yes ___ No ___ Thyroid Disease

HEMA/Lymph

- Yes ___ No ___ Bleeding/Clotting Disease
- Yes ___ No ___ Blood Transfusion
- Yes ___ No ___ Sickle Cell Anemia

Is there any other information that you wish to convey to your physician not mentioned above?
