DC Klinieken

Intake form Colonoscopy

Patient sticker

Date of intake: .....

Date of Colonoscopy: .....

Indication for Colonoscopy: .....

Screening programme ☐ Yes ☐ No

Medical information questions in "*italics*" are only applicable to the intake for the screening programme

Is the medical information from the GP present? ☐ Yes ☐ No

Has the colonoscopy centre requested additional medical information from the GP? ☐ Yes ☐ No

History of present illness:

How long have the symptoms been present? .....

Have you experienced:	Yes	No	Explanation
Abdominal pains?	☐	☐	.....
Abdominal cramping?	☐	☐	.....
Changes in defecation pattern?	☐	☐	
Changes in frequency?	☐	☐	
Changes in consistency?	☐	☐	.....
Consistency of the stools?			☐ watery ☐ thin ☐ paste-like ☐ solid ☐ rock hard ☐ with visible blood ☐ with mucous ☐ pencil shaped
Blood and/or mucous in the stools?	☐	☐	.....
Haemorrhoids?	☐	☐	.....
Anal fissures (= tears)?	☐	☐	.....
Painful need to pass stools?	☐	☐	.....
False alarm (feeling the need to defecate without any stools passing)?	☐	☐	.....
Increased flatulence?	☐	☐	.....

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Have you experienced:	Yes	No	Explanation
Unwanted weight gain? If yes, how much and in what time frame?	☐	☐	..... kg in ..... months
Unwanted weight loss? If yes, how much and in what time frame?	☐	☐	..... kg in ..... months
Decreased appetite?	☐	☐	.....
Have you undergone colonoscopy in the past, or suffered from intestinal polyps or colon cancer in the past?	☐	☐	.....
Fatigue?	☐	☐	.....
Chronic gastro-enteritis?	☐	☐	.....
Are you currently experiencing any (other) symptoms and how long have these existed for?	☐	☐	.....

Cardiac symptoms	Yes	No	Explanation
Do you see a cardiologist?	☐	☐	.....
Do you have a Pacemaker/ICD?	☐	☐	.....
Do you suffer from palpitations/does your heart sometimes skip a beat?	☐	☐	.....
Do you suffer from chest pains?	☐	☐	.....
Do you suffer from swollen feet?	☐	☐	.....
Do you have high blood pressure?	☐	☐	.....

Lung problems	Yes	No	Explanation
Do you see a pulmonologist?	☐	☐	.....
Do you have COPD?	☐	☐	.....
Do you often suffer from shortness of breath with exertion?	☐	☐	.....
Do you regularly experience respiratory problems? (coughing, wheezing, shortness of breath)	☐	☐	.....

HRMO / MRSA:

Are you HRMO or MRSA positive, or do you have any family members that have been HRMO/MRSA positive? ☐ Yes ☐ No

Have you recently (=<2 months ago) been admitted to a foreign hospital? ☐ Yes ☐ No

- If yes: was this for longer than 24 hours? ☐ Yes ☐ No
- Or shorter than 24 hours, but did you then have an operation, or had a drain or indwelling catheter inserted? ☐ Yes ☐ No
- Do you have any remaining skin lesions or abscesses related to the treatment in the foreign hospital? ☐ Yes ☐ No

Do you work with live pigs, veal calves or broiler chicks? ☐ Yes ☐ No

Have you been transferred here from a nursing facility that has experienced an outbreak of a HRMO/MRSA in the last 2 months? ☐ Yes ☐ No

Other problems	Yes	No	Explanation
Do you have Diabetes mellitus?	☐	☐	
Are you insulin-dependent?	☐	☐	
Are you pregnant?	☐	☐	
Do you have a disease affecting the muscles?	☐	☐	
Do you have glaucoma?	☐	☐	
Do you have epilepsy?	☐	☐	
Do you have a kidney disease or reduced kidney function?	☐	☐	
Do you have one or more artificial hip(s)?	☐	☐	

Family history	Yes	No	Explanation
Do you have two or more first degree family members with intestinal polyps? (currently or in the past)	☐	☐	
Have one or more first degree family members been diagnosed with colorectal cancer? Which family members and at what age?	☐	☐	

Lifestyle habits	Yes	No	Explanation
Smoking	☐	☐	
Alcohol	☐	☐	
Drugs	☐	☐	

Allergy	Yes	No	Explanation
Do you have any hypersensitivity to certain substances/materials or other allergies?	☐	☐	

Risk of delirium > 70 years	Yes	No	answered Yes 2/3x? Contact the patient's GP for background information.
Do you have any memory problems?	☐	☐	
Have you required assistance with self-care in the past 24 hours?	☐	☐	
Have there been any previous hospital admissions or periods of illness in which you became confused?	☐	☐	

Sedation	Yes	No	Explanation
Have you ever received sedation? How did you respond to that?	☐	☐	
Would like sedation (dormicum and (al)Fentanyl)	☐	☐	

Weight: _____ kg

Height: _____ cm

BMI (<35) (Weight: height^2) .....

Have you arranged transport for after the colonoscopy? ☐ ☐ .....

Can we use the veins on both the right and left side for the I.V.? ☐ ☐ .....

Use of medication	Yes	No	Explanation
Use of anticoagulants?	☐	☐	.....
Has the Anticoagulation Clinic been notified?	☐	☐	.....
Are you using iron tablets?	☐	☐	.....
Are you using sedative medication / sleeping pills?	☐	☐	.....

Medication	Dose
.....	.....
.....	.....
.....	.....
.....	.....

Relevant medical history/operations/illnesses (which and when):

Year:

....

....

....

....

Treatment decision

Is the colonoscopy necessary? ☐ Yes ☐ No

Are there any impediments to performing the colonoscopy? ☐ Yes ☐ No

Has an appointment for the colonoscopy been scheduled with the patient? ☐ Yes ☐ No

Sedation? ☐ Yes ☐ No

ASA score? 1 – 2 – 3 – 4

BP _____ mm/Hg Heart rate: _____

Current Medication Overview provided? ('AMO') ☐ Yes ☐ No

Is there someone who can guide you home and care for you there? ☐ Yes ☐ No

Informed consent - Part I

Has the patient been informed about the following during the intake consultation:

The aim of the colonoscopy	☐ Yes	☐ No
The procedure	☐ Yes	☐ No
The risks and possible complications (perforation, bleeding, respiratory depression)	☐ Yes	☐ No
The risks of an interval carcinoma following colonoscopy	☐ *Yes*	☐ *No*
The chances of finding polyps or colorectal cancer	☐ *Yes*	☐ *No*
The options for sedation and the procedure	☐ Yes	☐ No
The approach in special circumstances (colostomy, D.M., use of medication)	☐ Yes	☐ No
The preparation	☐ Yes	☐ No
Laxative medication provided/sent to home address?	☐ Yes	☐ No
The instructions for the day of the examination (has transport been arranged)	☐ Yes	☐ No
The follow-up care	☐ Yes	☐ No

Informed consent - Part II

Has the patient given consent during the intake consultation for obtaining additional information from their GP?	☐ *Yes*	☐ *No*
Has the patient given consent during the intake consultation for the agreed medical procedure?	☐ Yes	☐ No
Has the patient given consent during the intake consultation for the exchange of information with healthcare professionals outside the screening programme and DC Clinics?	☐ *Yes*	☐ *No*
Has the patient given consent during the intake consultation for the report of the colonoscopy to be forwarded to their GP?	☐ Yes	☐ No
Has the patient given consent during the intake consultation for the exchange of information from the intake consultation and the colonoscopy with the screening organisation (for the primary process, quality assurance and monitoring and evaluation of the screening programme)?	☐ *Yes*	☐ *No*

Date of intake: _____

Name + signature	Name + signature	Name + signature
nurse	**patient**	**Gastro-enterologist**