COLON & RECTAL SURGICAL SPECIALISTS OF NEW YORK

516-248-2422

www.CRSSNY.com

Locations in Nassau, Suffolk and Queens

INFORMED CONSENT FOR ANORECTAL PROCEDURES

You may undergo anoscopy or proctosigmoidoscopy as part of your rectal examination. These tests allow your doctor to look at the inner lining of your anus, rectum and the lower part of the colon. These tests are used to look for abnormal growths (such as tumors or polyps), inflammation, bleeding, hemorrhoids, and other conditions (such as diverticulosis).

You may be treated for one or more of the following conditions:
- Hemorrhoids
- Anorectal lesions
- Anal fissure
- Perirectal abscess

Nature and purpose of proposed treatment:
- Removal of painful and /or bleeding hemorrhoidal tissue; treatment of internal hemorrhoids with injection sclerotherapy, rubber band ligation and/or infrared coagulation
- Treatment of infection in perirectal area, with drainage and collection of any pus
- Treatment of anal fissure
- Removal of anorectal lesions

Risks common to all surgical procedures:
- Injury to a blood vessel or excessive bleeding
- Infection, which may require the use of antibiotics. In rare cases, another procedure may be necessary to remove the infection

Risks and possible complications of the proposed treatment:
- Pain after procedure, which may require the use of pain medication
- Bleeding
- Infection that may require the use of antibiotics. In rare cases, another procedure may be necessary
- Recurrence which may require another surgical procedure

I acknowledge and understand that prior to any procedure being performed, more specific instructions will be given to me. A diagnosis will be explained and I will have an opportunity to ask questions and have those questions answered. The procedure will proceed only when a verbal informed consent and this written informed consent have been obtained. I understand the above information and give my consent to have the described treatment performed.

_____ _____ _____

Print Name Patient Signature Date

(informed consent for anorectal procedures May 2018 CRSSNY)

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PATIENT QUESTIONNAIRE

Date: _____

Name: _____

Date of Birth: _____

E-mail address :_____
Please check here if you don't have an e-mail address or don't wish to disclose it._____

Profession: _____

Does your insurance require a referral?	Yes	No
Do you have a referral today?	Yes	No

What is the reason for today's visit?: _____

How long have you had this complaint? _____

History of Present Illness: _____
_____
_____
_____

How often do you have a bowel movement? _____

Are you having any rectal bleeding?	Yes	No
If yes, is the bleeding bright red or dark red?	Bright	Dark
If yes, is the blood mixed with the stool or not mixed with the stool?	Yes	No
Do you have any blood on the toilet paper?	Yes	No
Do you have blood in the toilet water?	Yes	No

Do you feel your rectum is falling out of your anus?	Yes	No
If yes, does the rectum go back in spontaneously?	Yes	No
If yes, do you ever have to push the rectum back in manually?	Yes	No
If yes, have you ever been unable to push the rectum back in?	Yes	No

Date: _____

Name: _____

Date of Birth: _____

Do you have severe pain around the anus?	Yes	No
Do you feel a ripping at the anus with bowel movements?	Yes	No
Do you have itching/burning at the anus?	Yes	No
Did you ever have anal warts?	Yes	No
Do you have drainage from the anus?	Yes	No
Are you incontinent to solid stool?	Yes	No
Are you incontinent to liquid stool?	Yes	No
Are you incontinent to gas?	Yes	No
If you have given birth, did you have birthing trauma requiring stitches?	Yes	No
Do you have abdominal pain or cramps?	Yes	No

If yes, what is the location? _____

Do you have a personal history of colon or rectal cancer?	Yes	No
Do you have a personal history of colitis?	Yes	No
Do you have a personal history of colon or rectal polyps?	Yes	No
Do you have a family history of colon or rectal cancer?	Yes	No
Do you have a family history of colonic polyps?	Yes	No
Have you ever had a colonoscopy?	Yes	No

If yes, date of last colonoscopy: _____

Current Medications: (Please include name and dosage. Include over-the-counter, herbal and natural)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies to Medications: (Please include name of medication and reaction)

_____ _____
_____ _____

Other Allergies:

_____ _____
_____ _____

Do you need antibiotics prior to dental procedures? Yes No

Do you have a history of cancer? If so, please indicate type of cancer and date.

_____

Do you have any cardiac (heart) issues? If so, please specify.

Date: _____

Name: _____

Date of Birth: _____

Past Medical History (please check any medical problems that you have had in the past):

__Anemia	__Depression	__Kidney stones
__Anticoagulation Therapy	__Diabetes	__Liver disease
__Anxiety	__Fatty liver	__MI (heart attack)
__Arthritis	__Fibromyalgia	__Osteoporosis
__Cancer	__GERD (heartburn)	__Pancreatitis
__Cataracts	__Heart disease or pacemaker	__Primary biliary cirrhosis
__Chronic lung disease	__Hepatitis B	__Primary sclerosing cholangitis
__Cirrhosis	__Hepatitis C	__Rashes/skin problem
__Colonic polyps	__High cholesterol	__Renal insufficiency
__Congestive heart failure	__High blood pressure	__Sleep apnea
__Coronary artery disease	__Inflammatory bowel disease	__Thyroid disease
__Crohn's disease	__Irritable bowel syndrome	__Ulcerative colitis
__Deep vein thrombosis	__Kidney disease	__Other (specify)_____

Females only, # of pregnancies _____ # of vaginal deliveries _____ # of c-sections _____

Past Surgical History: (Please list any surgeries and approximate year)

_____ _____
_____ _____
_____ _____

Were you ever hospitalized? (for any reason other than the above surgeries)
If yes, please list reason and approximate date.

_____ _____
_____ _____

Family History: (Please check below to report problems your family members might have had and the family members with the problem, e.g. "father with colon cancer"

_____ _____
_____ _____
_____ _____

Social History:

Smoking-- ____Current smoker How much do you smoke? _____

____Former smoker When did you quit?_____
____Never smoked

Did you have a drink containing alcohol in the past year? Please circle – Yes No
If yes, How often did you have a drink containing alcohol in the past year?_____
How many drinks did you have on a typical day when you were drinking in the past year?____
How often did you have 6 or more drinks on one occasion in the past year?_____

Height: _____ Weight: _____

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PATIENT REGISTRATION

Who are you seeing today? Dr. Dean Pappas/Dr. Frank Caliendo/Dr. Steven Pelaez/Dr. Mala Balakumar/ Dr. Cesar Sanz/Grace Halleran, PA

Last Name:_____ First:_____ MI:_____

Address:_____ City:_____State:_____ Zip:_____

Home #:_____-_____-_____Cell#_____-_____-_____Social Security#:_____-_____-_____

Place of Employment:_____ Work #:_____-_____-_____

What is your Date of Birth:_____/_____/_____ Age:_____

Circle One: Male/Female Marital Status: Single/Married/Divorced/Separated/Widowed

What is your E-mail Address?

_____@_____

Please check here if you don't have an e-mail address or don't want to disclose it._____

Who is your Family or Primary Care Physician?

Name:_____

Address:_____

Phone#:_____-_____-_____ Fax#:_____-_____-_____

Who may we thank for this referral?
Doctor/Friend/Family/Insurance Company/Internet/Other

If a Physician referred you, Who is the referring Physician:

Name:_____ Phone#:_____-_____-_____

Address:_____

Emergency Contact Information:

Name:_____Phone#:_____-_____-_____

Address:_____

What is your relationship to the above person?_____

Name:_____

Insurance Information

Does your insurance require a referral? Yes No
Do you have a referral today? Yes No

Primary Insurance Company:_____Policy#:_____

If insurance is under your spouse/parent for billing purposes, please provide:

Name:_____Date of Birth:_____/_____/_____SS#:_____/_____/_____

Secondary Insurance Co. Name:_____Policy#:_____

If under spouse/parent:_____Date of Birth:_____/_____/_____SS#:_____/_____/_____

Third Insurance Co. Name:_____Policy#:_____

If under spouse/parent:_____Date of Birth:_____/_____/_____SS#:_____/_____/_____

What is your Pharmacy Information?

Name:_____Phone#:_____-_____-_____

Address:_____

MEANINGFUL USE REQUIREMENT(government mandated)

Please Circle One:

Race: White, Hispanic, American Indian/Alaska Native, Asian, Black/African American, Native Hawaiian/Other Pacific Islander

Ethnicity: Hispanic/Non-Hispanic Preferred Language:_____

Social History –Please check ALL that apply:

Smoking Status: ( ) Never ( ) Former – When did you quit:_____
( )Current daily smoker – How many packs:_____
( )Current sometimes smoker- Explain:_____

Privacy Practices Acknowledgement:

I have Read/Received the notice of privacy practice and I have been provided an opportunity to review it. Due to the HIPPA Law, we are Not Allowed by Law to disclose any information pertaining to your medical condition, unless you authorize that information to be given.

INSURANCE ASSIGNMENT AND RELEASE:

I authorize the release of medical information necessary to process this claim and also authorize of medical benefits to the physician. I understand that it is my responsibility to present all insurance requirements to the office, i.e., insurance cards and referrals, and if I do not, I will be responsible for payment that day and will be reimbursed if I present such within 24 hours . By law, we must collect your carrier designated copay, deductible and co-insurance. Please be prepared to pay the copay at each visit. Should you not pay at the time of service and we subsequently send you a statement, a $10 charge will be added to your account. If there are reasons you cannot make your copay at each visit, arrangements MUST be made and approved in advance. Your signature below signifies your understanding and willingness to comply with this policy.

Patient Signature:_____**Date:**_____/_____/_____

(patient registration May 2018 CRSSNY revised)