The Reimer Clinic
So That No One Dies of Colon Cancer

1280 Old Innes Rd., Unit 802
Ottawa, ON, K1B 5M7

Phone: 613-366-2021
Fax: 613-366-2025
http://reimerclinic.ca

Patient Information

Please complete this information to help us serve you better.

Please circle: Mr. Mrs. Miss Ms Dr. Male Female

First Name:

Last Name:

Date of Birth: Month: Day: Year: Your Age Today:

Health Card Number: Version Code: Expiry Date:

Home Address (include postal code):

Home Phone: Work Phone: Cellular Phone:

Email:

Emergency Contact Name and Phone Number:

Family Doctor: Referring Doctor (if different):

How did you hear about us?

Today's Date:

The Reimer Clinic
So That No One Dies of Colon Cancer

1280 Old Innes Rd., Unit 802
Ottawa, ON, K1B 5M7

Phone: 613-366-2021
Fax: 613-366-2025
http://reimerclinic.ca

Patient Questionnaire

Thank you for choosing The Reimer Clinic. We welcome you as our patient. Please take the time to complete this health questionnaire so that we can provide you with the best care. If you have questions, we will be happy to answer them during your visit.

NAME (Please Print):

LARGE BOWEL QUESTIONS		
Have you had rectal bleeding? If yes: How often? (circle) DAILY WEEKLY RARELY	Yes	No
If yes: on the stool surface?	Yes	No
on the toilet paper?	Yes	No
in the toilet bowl?	Yes	No
Have you had tarry black stools? If yes: How often? (circle) DAILY WEEKLY RARELY	Yes	No
Do you have anal pain or discomfort?	Yes	No
If yes: With bowel movements?	Yes	No
after or between bowel movements?	Yes	No
Do you have frequent anal itching?	Yes	No
Do you have frequent anal mucous?	Yes	No
Do you have abdominal pain? If yes: Where? (circle) RIGHT MIDDLE LEFT UPPER MIDDLE LOWER Describe the pain: (circle) CRAMPY SHARP DULL INTERMITTENT CONTINUOUS	Yes	No
How often do you have a bowel movement? Times per day: _____ Times per week: _____		
Do you have straining or constipation?	Yes	No
Do you use laxatives? If yes: Which ones? (list)	Yes	No
Is there a change in your bowel habits lately? If yes: Explain:	Yes	No
Have you had a colonoscopy before?	Yes	No
If yes: Were any polyps found?	Yes	No
If yes: Date of last colonoscopy:		

Do you have unplanned weight loss?	Yes	No
UPPER GI SYMPTOMS		
Do you have frequent nausea or vomiting?	Yes	No
Do you have difficulty swallowing food or drink?	Yes	No
Do you have heartburn or acid reflux? If yes: How often? (circle) DAILY WEEKLY RARELY	Yes	No
Do you smoke? If yes: How many per day?	Yes	No
Do you consume alcohol? If yes: How many drinks per week?	Yes	No
Do you drink coffee? If yes: How many drinks per week?	Yes	No
Do you have a history of stomach ulcers?	Yes	No
Do you have a history of *H. Pylori* infection?	Yes	No
Have you had a gastroscopy before?	Yes	No
PAST MEDICAL HISTORY		
Do you have:		
limited mobility?	Yes	No
cardiac disease, high blood pressure, prior heart attack, prior stroke?	Yes	No
vascular disease or aneurysm?	Yes	No
lung disease or trouble breathing?	Yes	No
liver or kidney disease?	Yes	No
Hepatitis B, C, HIV or AIDS?	Yes	No
MRSE or VRE?	Yes	No
diabetes?	Yes	No
problems with anesthesia?	Yes	No
history of anxiety / depression / PTSD?	Yes	No

PAST MEDICAL HISTORY CONTINUED...
List any other medical history:

PAST SURGICAL HISTORY
List your prior surgeries:

MEDICATIONS
List your medications:

ALLERGIES
List your allergies:

OBSTETRIC HISTORY (if applicable)		
Are you now pregnant?	Yes	No
FAMILY HISTORY		
Do you have a family history of:		
colon or rectal cancer?	Yes	No
colon or rectal polyps?	Yes	No
other cancers? If yes: Which ones? (list)	Yes	No

RISK ASSESSMENT
What is your height? _____ feet and _____ inches OR _____ centimeters
What is your weight? _____ lbs OR _____ kg

Name: _____

Signature: _____

Date: _____

You may submit this form by fax (number above) or by email to results@reimerclinic.ca. Email is not encrypted or confidential. Your health information may be misdirected or intercepted. If you wish to send encrypted email to this address, use GPG. The public key for this address is on keyservers and the fingerprint is 0D44 C770 D1E8 0ED1 F84D 6ED6 E7BB 9740 CA09 1D46.

The Reimer Clinic
So That No One Dies of Colon Cancer

385 Frederick Street, Unit 6
Kitchener, ON, Canada, N2H 2P2

Phone: 519-957-9730
Fax: 519-957-9732

1280 Old Innes Rd., Unit 802
Ottawa, ON, K1B 5M7

Phone: 613-366-2021
Fax: 613-366-2025

http://reimerclinic.ca

Cancellation, No-Show and Non-Payment Policy

The Reimer Clinic strives to provide fast and efficient access to endoscopic care. When an appointment is scheduled, this date and time is reserved for you. Failure to attend appointments creates delay in providing care to you and it blocks access to care for others. It also creates considerable expense to the Clinic and to the health care providers whose livelihood depends on the services provided. Therefore, the Clinic requires 24 hours notice for cancellation and/or rescheduling of appointments. In this way we can try to accommodate another client in this slot who is waiting for care.

A cancellation fee applies if you cancel your appointment with less than 24 hours notice or if you do not attend your appointment, or if you arrive late. The cancellation fee is $400 for scheduled colonoscopies and $200 for scheduled gastroscopies and flexible sigmoidoscopies, to a maximum of $600. This fee will be waived if a doctors' note confirming an illness that prevents attendance is received within 96 hours of the missed appointment[1]. Procedures may also be canceled in person at the time of the appointment without charge.

If an appointment is canceled or rescheduled more than twice, the client will be sent back to the family physician for referral to another practice.

If my procedure is insured under OHIP: I acknowledge that I understand what a colonoscopy is. If I have had a colonoscopy before, I have indicated this on the Patient Questionnaire. I have also provided the accurate date of my last colonoscopy, in writing, on the Questionnaire. OHIP may deny payment for colonoscopy except once every 5 or 10 years. If The Reimer Clinic is not paid by OHIP because of an error or omission on my part about if and when I have had a previous colonoscopy, I agree to pay to The Reimer Clinic the amount of the claim denied by OHIP.

I understand this policy and I agree to abide by it. In the case of cancellation fee invoices not paid after 30 days, I agree that the debt may be sent to a collection agency.

Patient Name: _____

Patient Signature: _____

Date: _____

Appointment Date and Time: _____

1 Fees are charged under authority of Ontario Regulation 856/93, as amended (made under the *Medicine Act, 1991*), s. 1(1)20

The Reimer Clinic
So That No One Dies of Colon Cancer

385 Frederick Street, Unit 6
Kitchener, ON, N2H 2P2
Phone: 519-957-9730
Fax: 519-957-9732

1280 Old Innes Road, Unit 802
Ottawa, ON, K1B 5M7
Phone: 613-366-2021
Fax: 613-366-2025

http://reimerclinic.ca / http://cliniquereimer.ca

Consent and Waiver

I, _____ the undersigned give my permission to my physician at Mark Reimer Medicine Professional Corporation (The Reimer Clinic) and to assistants and delegates deemed appropriate by the doctor to perform the procedure(s) indicated below:

___ Colonoscopy, Biopsy, Polypectomy, possible Enteroscopy and possible Hemorrhoid Banding: Examination of the large intestine using a video endoscope. Tissue samples of abnormalities may be taken and polyps will be removed.

___ Flexible Sigmoidoscopy, Biopsy, Polypectomy and possible Hemorrhoid Banding: Examination of the rectum and sigmoid colon with a video endoscope.

___Upper Gastrointestinal Endoscopy (Gastroscopy): Examination of the upper digestive tract with a video endoscope.

___Other:

Specific Risks: Potential risks include, but are not limited to the following: infection, bleeding, bowel obstruction, perforation of the gastrointestinal tract and injury to adjacent organs such as the liver or spleen that may require additional surgery. Upper gastrointestinal endoscopy may also involve a slight risk to crowned teeth or dental bridgework.

General Risks: Potential risks include, but are not limited to the following: allergic reactions, irritation of the vein where medications are injected, aspiration of saliva or gastric contents, pneumonia, infection, cardiac or respiratory complications, injury or death from known or unknown causes.

General Understanding: I understand that the proposed procedure is in my best medical interest. I understand that colonoscopy will not detect 100% of polyps or cancer. If I have a new or persistent symptom, I should contact the clinic for further evaluation.

It is important that the bowel preparation instructions be followed exactly, and even then the colon may not be entirely free of stool, decreasing the quality of the examination.

I understand that I may choose to receive intravenous sedation. Sedation is offered, but it is optional.

I am aware that not all my care may be covered under OHIP. In that case, I will be informed of the fee before the service is rendered. I am aware of an optional Uninsured Services Fee / Block Fee to cover these services as an aggregate, if I choose to pay for them in this way. These services are listed on a rate-card available at the reception desk.

Initials:_____

Alternatives: There may be alternatives to this procedure to diagnose your problem, including x-rays or surgery. An alternative to having the procedure in an out-of-hospital facility is to have the procedure performed in a hospital.

Conclusion: I understand and appreciate the risks and benefits of the procedure and have had these explained to me. I have had an opportunity to ask my physician any questions I may have. These questions have been answered satisfactorily. I agree to have the procedure performed and accept the risks. I consent to any additional or alternative diagnostic or operative treatments or procedures that in the opinion of my doctor are immediately necessary and in the case of an unforeseen emergency, my doctor may make use of the assistance of other physicians, and may permit them to care for me. I acknowledge that no guarantees have been made to me concerning the result of this procedure.

Waiver: The physician and staff have explained to me the dangers of driving after sedation. I acknowledge that I understand these risks and will not drive for 24 hours after having sedation. I release and discharge the Reimer Clinic and associated persons from all liability, claims, losses, demands or damages caused by not following these instructions and by driving myself. I will indemnify the Reimer Clinic and all associated persons against any losses and liabilities including litigation costs and legal fees which may occur as a result of such claim.

Waiver: I am aware that I must bring a responsible adult driver to drive me home. The Reimer Clinic staff have explained to me the possible dangers of leaving the clinic unaccompanied after sedation. I acknowledge that I understand these risks and I release and discharge the Reimer Clinic and associated persons from all liability, claims, losses, demands or damages caused by not following these instructions and by leaving the Clinic unaccompanied. I will indemnify the Reimer Clinic and all associated persons against any losses and liabilities including litigation costs and legal fees which may occur as a result of such claim.

Name:

Signature:

Date: