

# Request for proposal

Requested by: (patient name, address, Email, & phone)  
Primary Care: (name & address of primary care doctor, if any)  
Test or Procedure: Screening Colonoscopy  
Date of request: (give current date)

## **Introduction:**

I am self pay (I have no medical insurance). Although colonoscopies may be considered routine by your practice, they are not routine for me. I am 59 and have never had one, nor do I expect to have more than two or three during my lifetime.

## **Priorities:**

My priorities are likely to be somewhat different from the average person. I prefer to have an active and knowledgeable role in any medical tests or medical care in which I participate. I prefer to be wide awake and in possession of full mental capacity during all tests and procedures whenever possible. I seek a provider who will communicate with me honestly and openly with respect for me and my feelings. These things are more important to me than remediation of pain, within reason, of course.

## **Requirements:**

### **1. Preview**

I must be able to meet with you and tour your facility prior to agreeing to the procedure without cost or obligation. Please provide the name and full contact information for your facility and what type it is (such as group practice office, hospital, stand alone clinic, etc.), as well as how to schedule such a visit.

### **2. Background**

Please explain what review of my medical records you may wish to make prior to performing the test. If necessary, I will provide written permission for you to review my medical records, currently on file with my primary care physician. If you wish to review my records prior to answering this RFP, please contact me.

### **3. Documents**

I expect you to provide a complete set of documents necessary for my inspection prior to my agreeing to undergo the procedure, including:

- any directions, steps for preparation, etc. before the procedure
- any history and/or consent forms I would have to complete and/or sign
- any directions, etc. for me to carry out after the procedure would be performed.

Documents can be in any form, such as on paper, sent as PDF files (not .doc) via Email, on web sites for downloading or printing, etc.)

### **4. Preparation**

Difficulty with preparation for colonoscopies is legend. I hear stories of nausea, fluids that are difficult to get down, bloating, cramping, extreme anal irritation from wiping, and so forth. Therefore, please provide a complete description of the prep regimen that you require for this test, how the prep you recommend compares with other prep regimens typically used, any alternatives you might provide or recommend, including whether colonic irrigation can be used and if so, in what way (in combination with other prep methods or as a substitute).

I am a low weight person with high metabolism. Since I expect the prep procedure may require that I limit my food intake, please explain what measures I would have to take to ensure maintenance of my blood sugar and nutrient levels during the prep period. I should note that I find that I have a reaction when eating some high sugar foods, so I limit them in my diet.

I understand that a percentage of patients arrive for this test who have not properly prepped. Please provide information as to what percentage of patients fail to prep properly, what errors they make, why they likely make them, and how I might avoid such errors. If I fail to prep properly, for any reason, what options are available (postponement of the test, alternative last minute prep regimen in your facility, etc.)

### **5. Drugs**

I would prefer to undergo the test without taking any drugs. If you advise me to take any drugs during the conduct of this test, please provide a complete list of them, including any with psychological effects, such as amnesiac or reduced mental capacity, vertigo, dizziness, drowsiness, or any other side effects. If any drugs can be self administered (such as patient activated pain medication delivery during the test, e.g. with 'push button' activation), please describe these options. If you require any drugs for this test (i.e. you are unwilling to conduct the test without my taking them), please indicate which drugs and why.

## 6. Support & Experience

I would like the option to have one or more friends accompany me as I undergo the test, including all phases of the test. Do you permit this in your facility? If so, are there any requirements for such persons that I should know ahead of time?

If possible, please provide me with descriptions of the sensations experienced during this test, or any other thoughts or suggestions, from other patients, that might help me to have a more relaxed experience and successful outcome. For instance, do different body positions during the test make a difference? Have some people found certain techniques help during prep that aren't typically given in the standard prep documents?

If there is pain during the test, is it best described as 'stabbing' or an 'ache' or 'pressure' etc? During the test, what means of emotional discharge are available, such as making sounds, gripping something, or physically shaking off fear and tension?

## 7. Results

I would like to understand how results of the test are handled. Please provide the following information:

- What conditions is the test expected to reveal?
- What percentage of patients tested have each of these results, industry wide and in your facility?
- What procedures, in general, are recommended as treatment for each result?
- What remedial procedures might be taken during the test (removal of polyps, cauterization, etc.)?
- What impact would these remedial procedures have on the test or during the follow up period (such as additional time to undergo the test, additional drugs, post test pain, effects, dietary limits, etc.)
- Do any remedial procedures that might be taken during the test carry an additional fee? If so, please provide a list (see also item 10, below).

## 8. Risks

Please provide the known risks of this test:

- of the prep
  - of the test itself
  - of any remedial procedures that might be performed during the test
- Please list of each type of risk and the likelihood of that risk occurring, by percentage, if possible, both industry wide, and in your facility, based on actual outcomes.

Have you or your facility been rated by any agency for quality of the performance of this test? Have you or your facility received responsible complaints or had adverse outcomes from the conduct of this test within the last ten years?

Are there any circumstances under which I would be advised to terminate the prep prematurely (such as side effects from prep agents, abdominal pain, etc.)?

What care would be needed to remediate each listed risk? In an emergency (such as bleeding, breach of membranes, sudden change in vital signs, etc.) how and where would the emergency be handled? Who would cover the cost for the remediation of these complications? Would decisions about the cost be handled on a case by case basis, depending on the cause (iatrogenic, versus patient condition, etc.)?

After the test is completed in your facility, assuming no complications requiring additional treatment, can I drive myself home?

## **9. Contact & Follow up**

Please provide a means by which I would contact you and/or appropriate personnel at your facility during the prep period, as well as during any recommended follow up period. This should include phone numbers, which hours I can call, what contact is available at night or during weekends, any Email or instant or text messaging access, emergency contact means, etc.

Are any follow up visits necessary or routine once the test is completed? If so, please provide a description.

## **10. Financial**

Finally, please give the cost of my having this test performed at your facility, based on the requirements listed in this document. This should include any breakdown you wish to provide, but must include a total, final comprehensive cost, including all materials, fees, etc. If I am expected to obtain prep materials or any other items on my own, either before or after the test, please list these, where they are typically obtained, and what their expected cost would be, so that I can calculate the total out of pocket cost to me for the entire experience, from beginning to end.

Please state any requirements you might have for a monetary deposit prior to the start of the test. Is a detailed invoice provided to me prior to completion of payments? When is payment in full required? Are time payment arrangements available? If I have questions or disagreements about the cost or billing, how are these handled? I would prefer to sit down and discuss things face to face with a single individual who has the authority and access to information to work things out with me.

Please give the time period (i.e., start date and end date) during which your quoted cost would remain in effect (i.e. before increases or changes). I may need to postpone the test for a variety of personal reasons.