Direct Screen Colonoscopy Program
Patient Questionnaire

MRN:
DOB: Age:
DOS: Sex:
Surgeon:

Patient Name: _____ Referral (Self / PCP): _____

Age: Ht: Wt: BMI: Est. Pt? Yes/ No _____

Basic Exclusions for Direct Screen Candidacy

_____ Do you have an AICD (implanted cardiac defibrillator)?

_____ Currently on any anti-coagulation or anti-platelet prescription medications? (Plavix, Coumadin, Xarelto, Aspirin)

_____ Currently under treatment for kidney disease, renal insufficiency or on dialysis?

Extended Exclusions for Direct Screen Candidacy

_____ Have you had a colonoscopy in the past 10 years?

_____ Personal history of colon cancer?

_____ Do you currently have rectal bleeding?

_____ History of diverticulitis?

_____ History of inflammatory bowel? (Crohn's disease or ulcerative colitis)

_____ Have you experienced unexplained abdominal pain recently?

_____ Have you experienced an unexplained or unintentional weight loss/gain recently?

_____ Have you had a recent change in bowel habits (constipation/diarrhea)?

Informational Only

_____ History of Sleep Apnea?

_____ History of difficulty with Anesthesia / Sedation?

_____ Family history of Colon Cancer?

- If yes, who? _____

ALLERGIES:

Is the patient a candidate? ☐ Yes ☐ No **Is the patient interested in the Direct Screen Program? ☐ Yes ☐ No**

Other Notes: _____

Info taken by: _____ Date: _____ Preferred Proc. Dates: _____

Phone: 954-266-3801 | Fax: 954-447-8970
www.surgicaremiramar.com

Date Discussed: _____
Date Scheduled: _____

Direct Screen Colonoscopy Program® Referral

Patient Name_____Height_____Weight_____

Patient's Date of Birth_____Patient's Email_____

Patient's Address_____

Patient's Home Phone_____Work_____Cell_____

Pharmacy_____Primary Physician:_____

Insurance_____

Policy Number_____Group Number_____

Primary card holder's name and date of birth_____

DIRECT REFERRAL FOR SCREENING COLONOSCOPY WITH:

☐ Narciso Gomez, MD ☐ Su Bin Kim, MD ☐ Rossana Moura, MD

☐ Zaid Rana, MD ☐ Ernesto Torres, MD

☐ First available provider ☐ Preferred procedure day:_____

Note In order for patients to be candidates of the Direct Screen Colonoscopy Program, the patient must NOT have any of the following symptoms:

☐ Rectal bleeding ☐ Dialysis ☐ Change in bowel habits ☐ Unexplained weight change ☐ Prescription Blood Thinners

☐ Patient is experiencing symptoms (check symptoms above) and needs to be seen for a regular office visit

Please fax request and copy of insurance to

TO BE FILLED OUT BY A REPRESENTATIVE OF SURGICARE:

Your patient has been scheduled for a screening colonoscopy on_____

with (provider name)_____

TO BE ORDERED BY PHYSICIAN OFFICE:

Prep Option (circle one): SURPREP* PLENVU* CLENPIQ* GOLYETLY* MOVI-PREP* MIRALAX*

*Prep to be ordered by Physician

Scheduler:_____**Phone #:**_____

Faxed To:_____**Fax #:**_____**Date Faxed:**_____