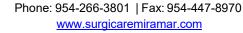
Direct Screen Colonoscopy Program

MRN: **Patient Questionnaire** DOB: Age: DOS: Sex: Surgeon: Referral (Self / PCP): Patient Name: ___ Wt: BMI: Est. Pt? Yes/ No Ht: Age: **Basic Exclusions for Direct Screen Candidacy** Do you have an AICD (implanted cardiac defibrillator)? Currently on any anti-coaquiation 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? o If yes, who? _____ ALLERGIES:

Is the patient a candidate? ☐ Yes ☐ No Is the patient interested in the Direct Screen Program? \square Yes \square No Other Notes: _____ Date:_____ Preferred Proc. Dates:_____ Info taken by:

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Scheduler:

Faxed To:_

Date Discussed:	
Date Scheduled:	

Phone #:_

Date Faxed:__

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	C	ell		
Pharmacy	Primar	y Physician:			
Insurance					
	Group Number				
	nd date of birth				
·					
DIRECT REFERRAL FOR SCREENING COLONOSCOPY WITH:					
□ Na	arciso Gomez, MD 🛛 Su Bin Kim, MD	□ Rossana N	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:					
\square Rectal bleeding \square Dialysis \square Change in bowel habits \square Unexplained weight change \square Prescription Blood Thinners					
\square 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 Physi				
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Fax #:_