



**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 dialysis?

BMI over 45?

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)?

Do you have a cardiac history?

Do you have chronic or active lung disease? Are you on oxygen at home?



History of liver disease?

History of paralysis?

History of seizures?

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? Yes No

Other Notes: _

Info taken by: _____

Date: _

Preferred Proc. Dates: _



Phone: 301-430-5025 | Fax: 301-490-5260

Email:

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/ Face Sheet Attached _____
Policy Number _____ Group Number _____
Primary card holder's name and date of birth _____

DIRECT REFERRAL FOR SCREENING COLONOSCOPY WITH:

Provider Name

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 or unintentional 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: Endoscopy ASC of Middle Georgia

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:** _____