



7625 Maple Lawn Blvd.
Ste. 110
Fulton, MD 20759
Phone: 301-490-5025, Fax: 301-490-5260

Patient Name _____ Height _____ Weight _____
Patient's Date of Birth _____ Patient's Email _____
Patient's Address _____
Patient's Home Phone _____ Work _____ Cell _____
Pharmacy _____
Insurance _____
Policy Number _____ Group Number _____
Primary card holder's name and date of birth _____

DIRECT REFERRAL FOR SCREENING COLONOSCOPY WITH DR.

Note: 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

**** If the patient is experiencing symptoms (circle symptoms above), BGA will arrange for them to be seen for a regular office visit by one of the providers at St. Francis Medical Practice prior to their procedure.**

Referring Physician _____

Phone # _____

Fax # _____

Please fax request and copy of insurance to (301) 490-5025

To be filled out Surgery Center or GI Provider representative:

Your patient has been scheduled for a screening colonoscopy on: _____
at Maple Lawn Surgery Center, LLC _____

Prep kits are available for pickup at the surgery center or the pt may purchase the items from their local drug store. (Two (2) bottles of Magnesium Citrate and Six (6) bisacodyl tablets). Instructions will be texted and/or emailed to the patient.

Thank You for the Referral!