Queen's Colon Screening Program (QCSP)
Direct Screening Colonoscopy Referral Form

550 South Beretania St. POB III Suite 701 Honolulu, HI 96813
Office Phone: 691-8270 / Fax: 691-8278

Date of referral: _____/_____/_____

Patient Full Name: _____ Gender: _____ DOB: ___/___/___

Address: _____ City: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Insurance: _____ ID#: _____ Secondary Insurance: _____ ID#: _____

Please confirm patient meets criteria for direct screening by checking the boxes below:

☐ **NO Rectal Bleeding**

☐ **NO Abdominal Pain**

☐ **NO Change in Bowel Habits**

If patient is having any type of these symptoms, they are ineligible for the Direct Screening Process and will be referred to a GI physician for consultation

---

Physician Signature: _____ Physician's Name (Print): _____

Office Contact Name: _____ Office Contact # (if different): _____

Address: _____

Phone #: _____ Fax #: _____

*Please fax patient's most recent progress note along with this referral