Patient Name:
DOB:
Patient's Phone Number:
Referring MD:

Approximate date of last colonoscopy: _____

Location of last colonoscopy: _____

SCREENING COLONOSCOPY FAST TRACK FORM

*If your patient answers **NO** to all these questions, please fax this form to **509-418-2971.**
We will be in contact with the patient within 48 business hours.

*If your patient answers **YES** to any of these questions, please fax this to **509-838-5961**.

Fast Track Screening Questionnaire	YES	NO
Age less than 45 or greater than 75		
Needs an interpreter		
Has had an EGD in the last 2 years When: Where:		
Dx of Crohn's Disease or Ulcerative Colitis		
Seizure Disorder		
Dx of OSA or wears CPAP/BIPAP		
HX of anesthesia complications or difficult airway		
Takes insulin or GLP1 for DM		
BMI greater than 40		
HX CKD or on dialysis		
Taking blood thinners		
Lung Conditions		
Heart Conditions		

****Please attach pt demographics, most recent chart note and if needed, referral auth****