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 excluding HTN		

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