GI FAST TRACK – Direct Access Colonoscopy Referral Form

Center for Digestive Health
Phone: 407-241-3205

Please complete form, return with demographics, copy of insurance card, and recent H&P to: Secure Email: directaccess@cdhfl.com or dedicated Fax#: *407-219-4585*

PATIENT INFORMATION

Date_____

Patient Name: _____

DOB: _____ Patient Phone#: _____

Referring Provider: _____

Referring Office Phone: _____ Fax: _____

Insurance: _____Member ID: _____

Primary Care Provider (if different than referring): _____

REFERRING PROVIDER AUTHORIZATION

GI Provider Name: _____

Referral/Auth #: _____

GI FAST TRACK ELIGIBILITY (ALL MUST BE YES)

☐ Age 45–65 ☐ NO GI symptoms ☐ Average colorectal cancer risk ☐ No prior colonoscopy

☐ Patient able to follow prep instructions

****EXCLUSION – REQUIRES CONSULT IF ANY BELOW APPLY.**

☐ Rectal bleeding ☐ Iron deficiency anemia ☐ Weight loss

☐ Persistent abdominal pain ☐ Change in bowel habits ☐ Positive FIT/Cologuard

☐ Personal history polyps or colorectal cancer/Family history of colorectal cancer/polyps

☐ IBD (Crohn's/Ulcerative Colitis) ☐ Prior colon resection ☐ Chronic diarrhea ☐ Severe constipation

MEDICAL HISTORY

Cardiac disease: ☐ No ☐ Yes- Describe_____

Pulmonary disease: ☐ No ☐ Yes- Describe_____

Vascular disease: ☐ No ☐ Yes- Describe_____

MEDICATIONS

Anticoagulants: ☐ None ☐ Aspirin ☐ Plavix ☐ Eliquis ☐ Xarelto ☐ Pradaxa ☐ Warfarin ☐ Other _____

GLP-1/SGLT-2: ☐ None ☐ Name: _____

Medication allergies: _____

BMI: _____

Medications: _____

FOR CENTER FOR DIGESTIVE HEALTH USE ONLY:

☐ Approved for Direct Colonoscopy-Mid-Level Review ☐ Requires Office Consultation