



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): _____

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 _____

Medication allergies: _____

BMI (if known): _____

MEDICATIONS

Anticoagulants: None Aspirin Plavix Eliquis Xarelto Pradaxa Warfarin Other _____

GLP-1/SGLT-2: None Name: _____

REFERRING PROVIDER AUTHORIZATION

GI Provider Name: _____

Referral/Auth #: _____

FOR CENTER FOR DIGESTIVE HEALTH USE ONLY

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