

**Edmonton Zone FAST Program**  
 Facilitated Access to Surgical Treatment

Affix patient label within this box

\*\*\*Must Include a valid mailing address and email address if available \*\*\*

**General Surgery Referral**

Phone: 780-735-8114 Fax: 780-735-4825

Email: ezgensurgconsults@ahs.ca

 ■ All referrals require this **form, a complete referral letter and relevant supporting documents**

■ Please fax each referral individually

<input type="checkbox"/> <b>Refer to the next available surgeon</b> ( <i>shortest wait time</i> ) <b>OR</b> Refer to specific hospital or surgeon <u>Judy Jones</u> ( <i>wait time may be longer</i> )	
<input type="checkbox"/> <b>Symptomatic Gallstones or Gallbladder Polyps</b> - <i>Must include the following within three months of referrals</i> <div style="display: flex; justify-content: space-between;"> <span><input type="checkbox"/> Abdominal Ultrasound</span> <span><input type="checkbox"/> Liver Function Test (ALT, AST, ALK PHOS, TBILI)</span> </div>	
<input type="checkbox"/> <b>Severe Gastro-Esophageal Reflux</b> ( <i>Requiring surgery</i> )	
<b>Colorectal</b> ( <i>Rectal assessment Sheet and DRE Results Required</i> )	
<input type="checkbox"/> High-Risk Symptoms <input type="checkbox"/> Rectal Prolapse <input type="checkbox"/> Symptomatic Diverticula Disease <input type="checkbox"/> Positive FIT ( <i>only for patients NOT eligible or DECLINED by the SCOPE and/or the SHARP program</i> ) Reason for ineligibility _____	<input type="checkbox"/> Anal Fissure <input type="checkbox"/> Anal Fistula <input type="checkbox"/> Fecal Incontinence <input checked="" type="checkbox"/> Pilonidal Sinus <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Rectal Bleeding
<b>Hernia</b> ( <i>symptomatic, physical exam completed, no ultrasound required</i> )	
<input type="checkbox"/> Inguinal <input type="checkbox"/> Bilateral Inguinal <input type="checkbox"/> Recurrent Inguinal	<input type="checkbox"/> Incisional <input type="checkbox"/> Umbilical <input type="checkbox"/> Other _____
<b>Cancers</b> ( <i>include symptoms and relevant imaging</i> )	
<input type="checkbox"/> Suspected Gallbladder Cancer <input type="checkbox"/> Suspected Sarcoma/GIST <input type="checkbox"/> Suspected Liver cancer <input type="checkbox"/> Suspected Pancreatic/Bile Duct Cancer <input type="checkbox"/> Suspected Stomach Cancer	<input type="checkbox"/> Suspected Colorectal Cancer ( <i>Include Rectal Assessment Sheet</i> ) <input checked="" type="checkbox"/> Adrenal Mass <input type="checkbox"/> Neck Mass <input type="checkbox"/> Thyroid Mass ( <i>include ultrasound report and FNA results</i> )
<b>Minor Operations</b>	
<input type="checkbox"/> Lipoma ( <i>include size and location</i> ) ( <i>no joints</i> ) <input type="checkbox"/> Sebaceous Cyst ( <i>include size and location</i> ) ( <i>no joints</i> ) <input type="checkbox"/> Temporal Artery Biopsy	<input type="checkbox"/> Sural Nerve Biopsy <input type="checkbox"/> Muscle Biopsy <input type="checkbox"/> Lymph Node Biopsy ( <i>include FNA results</i> )
<b>Other Condition</b> <input type="checkbox"/> _____ _____	

\*\*\*If you have not received notification from our program within 7 days please call to confirm receipt