



# **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](mailto:ezgensurgconsults@ahs.ca)

- All referrals require this form, a complete referral letter and relevant supporting documents
  - Please fax each referral individually

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

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