

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

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