



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"/> Refer to the next available surgeon (shortest wait time)	
OR Refer to specific hospital or surgeon <u>John Doe</u> (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>	
Colorectal <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 checked="" 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"/> Reason for ineligibility <u>Allergy</u>	<input type="checkbox"/> Hemorrhoids
	<input type="checkbox"/> Rectal Bleeding
Hernia <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 _____
Cancers <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 checked="" 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	
Minor Operations	
<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>
Other Condition	
<input type="checkbox"/> _____	

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