



# **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 type="checkbox"/> Refer to the next available surgeon (shortest wait time)		
OR Refer to specific hospital or surgeon Michael Moor	(wait time may be longer)	
<input type="checkbox"/> Symptomatic Gallstones or Gallbladder Polyps - Must include the following within three months of referrals		
<input type="checkbox"/> Abdominal Ultrasound	<input type="checkbox"/> Liver Function Test (ALT, AST, ALK PHOS, TBILI)	
<input type="checkbox"/> Severe Gastro-Esophageal Reflux (Requiring surgery)		
<b>Colorectal (Rectal assessment Sheet and DRE Results Required)</b>		
<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 (only for patients NOT eligible or DECLINED by the SCOPE and/or the SHARP program)	<input type="checkbox"/> Pilonidal Sinus	
Reason for ineligibility _____	<input type="checkbox"/> Hemorrhoids	
	<input type="checkbox"/> Rectal Bleeding	
<b>Hernia (symptomatic, physical exam completed, no ultrasound required)</b>		
<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 (include symptoms and relevant imaging)</b>		
<input type="checkbox"/> Suspected Gallbladder Cancer	<input type="checkbox"/> Suspected Colorectal Cancer (Include Rectal Assessment Sheet)	
<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 (include ultrasound report and FNA results)	
<input type="checkbox"/> Suspected Stomach Cancer		
<b>Minor Operations</b>		
<input checked="" type="checkbox"/> Lipoma (include size and location) (no joints)	<input type="checkbox"/> Sural Nerve Biopsy	
<input type="checkbox"/> Sebaceous Cyst (include size and location) (no joints)	<input type="checkbox"/> Muscle Biopsy	
<input type="checkbox"/> Temporal Artery Biopsy	<input type="checkbox"/> Lymph Node Biopsy (include FNA results)	
<b>Other Condition</b>		
<input type="checkbox"/> _____		

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