

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

Refer to the next available surgeon (shortest wait time)

OR Refer to specific hospital or surgeon Timothy Trust (wait time may be longer)

Symptomatic Gallstones or Gallbladder Polyps - Must include the following within three months of referrals

Abdominal Ultrasound Liver Function Test (ALT, AST, ALK PHOS, TBIL)

Severe Gastro-Esophageal Reflux (Requiring surgery)

Colorectal (Rectal assessment Sheet and DRE Results Required)

- | | |
|--|---|
| <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 |

Hernia (symptomatic, physical exam completed, no ultrasound required)

- | | |
|---|--------------------------------------|
| <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 (include symptoms and relevant imaging)

- | | |
|--|--|
| <input type="checkbox"/> Suspected Gallbladder Cancer | <input type="checkbox"/> Suspected Colorectal Cancer (Include Rectal Assessment Sheet) |
| <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 (include ultrasound report and FNA results) |
| <input type="checkbox"/> Suspected Stomach Cancer | |

Minor Operations

- | | |
|---|--|
| <input type="checkbox"/> Lipoma (include size and location) (no joints) | <input checked="" 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) |

Other Condition

- _____

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