

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 _____ (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)	
Colorectal (Rectal assessment Sheet and DRE Results Required)	
<input type="checkbox"/> High-Risk Symptoms <input type="checkbox"/> Rectal Prolapse <input type="checkbox"/> Symptomatic Diverticula Disease <input type="checkbox"/> Positive FIT (only for patients NOT eligible or DECLINED by the SCOPE and/or the SHARP program) Reason for ineligibility _____	<input type="checkbox"/> Anal Fissure <input type="checkbox"/> Anal Fistula <input type="checkbox"/> Fecal Incontinence <input type="checkbox"/> Pilonidal Sinus <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Rectal Bleeding
Hernia (symptomatic, physical exam completed, no ultrasound required)	
<input type="checkbox"/> Inguinal <input type="checkbox"/> Bilateral Inguinal <input type="checkbox"/> Recurrent Inguinal	<input type="checkbox"/> Incisional <input type="checkbox"/> Umbilical <input type="checkbox"/> Other _____
Cancers (include symptoms and relevant imaging)	
<input type="checkbox"/> Suspected Gallbladder Cancer <input type="checkbox"/> Suspected Sarcoma/GIST <input type="checkbox"/> Suspected Liver cancer <input type="checkbox"/> Suspected Pancreatic/Bile Duct Cancer <input type="checkbox"/> Suspected Stomach Cancer	<input type="checkbox"/> Suspected Colorectal Cancer (Include Rectal Assessment Sheet) <input type="checkbox"/> Adrenal Mass <input type="checkbox"/> Neck Mass <input type="checkbox"/> Thyroid Mass (include ultrasound report and FNA results)
Minor Operations	
<input type="checkbox"/> Lipoma (include size and location) (no joints) <input type="checkbox"/> Sebaceous Cyst (include size and location) (no joints) <input type="checkbox"/> Temporal Artery Biopsy	<input type="checkbox"/> Sural Nerve Biopsy <input type="checkbox"/> Muscle Biopsy <input type="checkbox"/> Lymph Node Biopsy (include FNA results)
Other Condition <input checked="" type="checkbox"/> Allergies _____ _____ _____	

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