



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 - <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 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"/> Hemorrhoids | <input type="checkbox"/> Rectal Bleeding |
| Reason for ineligibility _____ | |
| 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 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 checked="" type="checkbox"/> Allergies | |

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