



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 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 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	
Reason for ineligibility _____	<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 type="checkbox"/> Suspected Sarcoma/GIST	<input type="checkbox"/> Adrenal Mass	
<input type="checkbox"/> Suspected Liver cancer	<input checked="" 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</i>) (<i>no joints</i>)	<input type="checkbox"/> Sural Nerve Biopsy	
<input type="checkbox"/> Sebaceous Cyst (<i>include size and location</i>) (<i>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**