Alberta Health Services

Last Name *(Legal)*		First Name *(Legal)*
Preferred Name ☐ Last ☐ First		DOB*(dd-Mon-yyyy)*
PHN	ULI ☐ Same as PHN	MRN
Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X) ☐ Unknown		

Facilitated Access to Specialized Treatment (FAST) Colposcopy Referral

Phone: 780-735-8114 Email: EZGynecologyReferrals@ahs.ca

All referrals require this form and relevant supporting documents

Fax each referral individually to **780-643-1491**

TOP website for referral guidelines:
https://actt.albertadoctors.org/CPGs/Lists/CPGDocumentList/Cervical-Cancer-Screening-CPG.pdf

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

Referring Physician	Primary Care Physician
Name	Name
Phone	Phone
PRAC ID	PRAC ID

Referral Information

Type of Request

☐ New Referral *(choose one)*

☐ Refer to the next available clinic *(shortest wait time)*

OR

☐ Refer to a specific site or physician *(wait time may be longer)*

Specify site/physician ______________________________

☐ Re-referral *(this info is REQUIRED if patient has been seen in colposcopy prior)*

Previous site and physician ______________________________

Reason for referral

Abnormal Cytology

Higher Risk *(book within **6 weeks** of referral)*

☐ HSIL

☐ ASCH

☐ AGC, AIS, Edometrial cells on a PAP

Lower Risk *(book within **6 months** of referral)*

☐ ASCUS HPV +

☐ LSIL HPV +

☐ Persistent LSIL

☐ Persistent ASCUS

Suspected Malignancy Requiring Biopsy

*(book within **2 weeks** of referral to Gyn oncologist)*

Referral letter required for triage

☐ Cervical Cancer

☐ Vulvar Cancer

☐ Vagina Cancer

Other

Referral letter required for triage

☐ Clinical Abnormality

☐ See and Treat *(HSIL or AIS on biopsy requiring LEEP)*

☐ Vulvar lesion

☐ Other ______________________________