

## **Facilitated Access to Specialized Treatment (FAST)** Adult General Surgery Referral

To confirm fax numbers and other clinic information visit www.albertareferraldirectory.ca and search for Facilitated Access to Specialized Treatment.

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

f you have not received notification from	our prog	gram within 5 bus	siness d	ays, please call	FAST at <b>1.833.5</b>	53.3278
Date (dd-Mon-yyyy)	Patient Primary Phone Patient Secondary Phone				ary Phone	
Patient Address						
Legal Guardian Name		Phone		Relationship		
Referring Provider F		Phone		Fax		PRAC ID
linic Address		Primary Care Provider and Contact Info (if available)				
Indicate if you provide specialty care in ☐ General Surgery		wing areas <i>(check</i> stroenterology	all that ap	pply)		
Requested Provider						
□ Next Available Provider <b>OR</b>		☐ Specific F	Provider			
Location Preference						
☐ Previously seen by the following surg	eon for	he same probler	n (specify	name)		
Referral Requirements		<u> </u>				
Attach referral letter <b>OR</b> complete information as per the <a href="https://www.albertahealthservices.ca/as">https://www.albertahealthservices.ca/as</a>	e Provir	cial General Sur	gery Re	•	ferral-pathway.po	<u>df</u>
Reason for Referral						
Gastrointestinal (choose one)  □ Disorder of GI Tract □ Chronic Abdominal Pain		Colorectal Cancer Screening/Surveillance (choose one)  □ FIT Positive Finding □ Family History of Colorectal Cancer □ Personal History of Colorectal Cancer				
Minor Procedures (choose one)			Colore	ctal (choose one)		
□ Symptomatic Lipoma Excision □ Sebaceous Cyst Excision □ Temporal Artery biopsy □ Sural Nerve Biopsy □ Muscle Biopsy □ Lymph Node Biopsy		□ Rectal Bleeding □ Diverticulitis □ Fecal Incontinence □ Disorder of the Anal Region □ Pilonidal Disease □ Rectal Prolapse □ Abnormal Imaging of GI Tract				
Mass Cancers (choose one)			Hernia	(choose one)		
□ Anal LSIL/HSIL □ Esophageal Mass □ Rectal/Anal Cancer □ Suspected/Known Colon Cancer □ Suspected/Known Stomach Cancer			□ <u>Incis</u>	nal Hernia ional Hernia ilical Hernia r Abdominal Hel	<u>rnia</u>	
□ Suspected/Known Soft Tissue Cance □ Neck Mass	<u>r</u>					

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Preferred Name □ Last □ First		DOB(dd-Mon-yyyy)	
PHN	ULI □ Same as PHN		MRN
Administrative Gend  ☐Non-binary/Prefer			☐ Female ☐ Unknown

First Name (Legal)

Last Name (Legal)

All referrals require this form, a complete referral letter and relevant supporting documents. To confirm fax numbers and other

clinic information visit <u>www.albertareferraldi</u>	irecto	ory.ca and search for Facilitated Access	to Specialized Treatment.				
Reason for Referral (continued)							
Hepatobiliary (choose one)		Endocrine (choose one)					
□ Symptomatic Gallstones □ Gallbladder Polyps □ Gallbladder Mass □ Pancreatic Mass		□ Adrenal Mass □ Suspected Neuroendocrine Tumor □ Suspected Parathyroid Disease □ Thyroid Mass					
Venous Disorders (choose one)		Breast Health (choose one)					
□ <u>Uncomplicated (varicose vein)</u> □ <u>Complicated (ulceration, phlebitis, or bleeding)</u>		□ Benign Breast Disease (Medicine Hat, Calgary Zone and North Zone only) □ Suspected/Known Breast Cancer (Medicine Hat only) For Suspected/Known Breast Cancer in all other areas: refer to zone breast					
		health/care program.	er in an other areas. Telef to 2011e breast				
Other (specify)							
Height (cm)	We	ight (kg)	BMI				
□ Referral letter attached <b>OR</b> □ All re	eleva	nt information is provided below					

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