Alberta Health Services

Facilitated Access to Specialized Treatment (FAST)
Non-Urgent Adult Orthopedic & Spine Referral

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	

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

If you have not received notification from our program within 5 business days, please call FAST at **1.833.553.3278**

Date *(dd-Mon-yyyy)*	Patient Primary Phone	Patient Secondary Phone	
Patient Address			
Legal Guardian Name	Phone	Relationship	
Referring Provider	Phone	Fax	PRAC ID
Clinic Address	Primary Care Provider and Contact Info *(if available)*		

Do you provide specialty care in any of the following areas? *(check all that apply)*

☐ Orthopedic Surgery
☐ Physiatry
☐ Neurology
☐ Sport Medicine
☐ Rheumatology
☐ Family Medicine working within a multidisciplinary MSK assessment program

Requested Provider

☐ Next Available Provider **OR** ☐ Specific Provider _____

Location Preference _____

☐ Previously seen by the following surgeon for the same problem *(specify name)* _____

Referral Requirements

Attach referral letter **OR** complete information on bottom of **page 2**.
Include results of mandatory investigations as per the Provincial Adult Orthopedic & Spine Referral Pathway:
https://www.albertahealthservices.ca/assets/info/hp/arp/if-hp-arp-asi-orthopaedics-qr.pdf

Reason for Referral

☐ Left
☐ Right

Presumptive Diagnosis *(if applicable)*

Dominant Hand *(applicable to Shoulder/Elbow/Hand and Wrist Referrals)* ☐ Left ☐ Right

Shoulder *(choose one)*

☐ Pain
☐ Stiffness
☐ Instability
☐ Retained Hardware

Elbow *(choose one)*

☐ Arthritis
☐ Non-degenerative Joint Pathology
☐ Chronic Soft Tissue Pain
☐ Entrapment Neuropathy
☐ Mass *(tumor or lump)*
☐ Olecranon Bursitis

Hand and Wrist *(choose one)*

☐ Arthritis of Hand
☐ Arthritis of Wrist
☐ Carpal Tunnel Syndrome
☐ Median Nerve Entrapment
☐ Radian Nerve Entrapment
☐ Ulnar Nerve Entrapment
☐ Pain - Hand
☐ Pain - Wrist
☐ Ligament Pathologies - Hand
☐ Ligament Pathologies - Wrist
☐ Tendon Pathologies - Hand & Wrist
☐ Mass *(tumor or lump)*
☐ Deformity

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Reason for Referral *(continued)*

Hip *(choose one)*

- ☐ Arthritis
- ☐ Symptomatic Hip Arthroplasty
- ☐ Pain *(without osteoarthritis)*
- ☐ Hip Impingement
- ☐ Congenital Hip Dysplasia
- ☐ Bone Deformity *(other)*
- ☐ Avascular Necrosis *(AVN)* *(without osteoarthritis)*
- ☐ Synovial Disorder
- ☐ Residual Childhood Hip Disorder
- ☐ Retained orthropedic Hardware

Knee *(choose one)*

- ☐ Arthritis
- ☐ Pain *(without OA)*
- ☐ Instability
- ☐ Mechanical Symptoms
- ☐ Retained Hardware

Foot and Ankle *(choose one)*

- ☐ Pain
- ☐ Instability
- ☐ Swelling
- ☐ Deformity
- ☐ Ulcer

Injury greater than 4 weeks old *(choose one)*

Acute injuries less than 4 weeks require contacting the on-call surgeon.

- ☐ Specify Site _____
- ☐ Fracture
- ☐ Suspected Tendon Rupture

Spine *(choose one)*

- ☐ Radiculopathy *(cervical or lumbar)*
- ☐ Neurogenic Claudication
- ☐ Myelopathy *(cervical or thoracic)*
- ☐ Spinal Deformity
- ☐ Back pain *(w/o neurological symptoms)*
- ☐ Neck Pain *(without radiculopathy)*

Other *(specify)*

Height (cm)	Weight (kg)	BMI

(check one)

☐ Referral letter attached **OR** ☐ All relevant information is provided below