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) Elective Hand & Wrist Surgical Referral

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

All referrals require this form, and a **complete referral letter**.
Attach any **imaging/electrodiagnostic study results completed** *(but not required)*.

Fax each referral individually to **780-643-1235**

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

Referring Physician

Name

Phone | PRAC ID

Referral Information

Type of Request *(choose one)*

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

☐ Refer to a specific site or surgeon *(wait time may be longer)*
Specify site/surgeon________________________________

WCB Patient?
☐ Yes ☐ No

☐ **Fracture/Dislocation/Tendon laceration** *(non-acute)*
Location ______________________________ Date of Injury *(dd-Mon-yyyy)* ____________________________

Injuries less than 4 weeks *should be referred to the on-call surgeon (Plastics at UAH/RAH or Orthopedics at Sturgeon/WULF)*

☐ **Hand** Location/Specific condition ________________________________

- ☐ Masses
- ☐ Dupuytren's contracture
- ☐ Stiff finger
- ☐ Trigger finger
- ☐ Tenosynovitis *(e.g. De Quervain's, intersection syndrome)*
- ☐ Thumb arthritis
- ☐ Finger arthritis
- ☐ Rheumatoid hand deformities
- ☐ Tendon related deformity *(e.g. mallet finger, Jersey finger, Boutonniere's)*

☐ **Wrist** Location/Specific condition ________________________________

- ☐ Wrist arthritis
- ☐ Ligament injuries *(e.g. Scapholunate ligament, Lunotriquetral ligament, TFCC)*
- ☐ Joint instabilities *(e.g. DRUJ, midcarpal)*
- ☐ Kienbock's disease
- ☐ Masses
- ☐ Tendon pathologies *(e.g. instability, tendonitis, tear)*
- ☐ Undiagnosed wrist pain
  Location *(e.g. radial/central/ulnar, volar/dorsal)*:
  ____

☐ **Nerve** Location ________________________________

- ☐ Carpal Tunnel Syndrome
- ☐ Ulnar neuropathy *(associated elbow stiffness/arthritis)*
- ☐ Radial neuropathy

Note: *Peripheral nerve injuries should be referred to the Glenrose Peripheral Nerve Injury Clinic (Phone 780-735-8811, Fax 780-735-8873)* ***See Alberta Referral Directory***

☐ **Failed Surgery** *(attach operative reports and other pertinent investigations)*

☐ **Other Condition** ________________________________

Non-Surgical Treatments Attempted *(check all that apply, and indicate level of relief from treatment)*

Treatment			
☐ Physiotherapy	☐ Good	☐ Moderate	☐ No Relief
☐ Injections	☐ Good	☐ Moderate	☐ No Relief
☐ NSAID/COXIB	☐ Good	☐ Moderate	☐ No Relief
☐ Splinting	☐ Good	☐ Moderate	☐ No Relief
☐ Other ________________	☐ Good	☐ Moderate	☐ No Relief