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** *(cytology).*

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 colposcopist *(shortest wait time)*

OR

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

Specify site/physician _____

☐ Re-referral *(if seen in colposcpopy prior)*

Previous site and physician _____

Reason for referral

Abnormal Cytology

Higher Risk *(book within **3 months** of referring cytology)*

☐ HSIL
☐ ASCH
☐ AGC/AIS

Lower Risk *(book within **6 months** of referring cytology)*

☐ ASCUS HPV +
☐ LSIL HPV +
☐ Persistent LSIL
☐ Persistent ASCUS

Suspected Malignancy

*(book within **2 weeks** to oncology provider)*

Referral letter required for triage

☐ Cervical Cancer
☐ Vulvar Cancer
☐ Vagina Cancer

Other

Referral letter required for triage

☐ Clinical Abnormality
☐ See and Treat *(HSIL/AIS biopsy proven)*
☐ Vulvar lesion
☐ Other _____