

## Facilitated Access to Specialized Treatment (FAST) Plastic Surgery Referral – Adult

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

Last Name <i>(Legal)</i>		First Name <i>(Legal)</i>	
Preferred Name <input type="checkbox"/> Last <input type="checkbox"/> First		DOB <i>(dd-Mon-yyyy)</i>	
PHN	ULI <input type="checkbox"/> Same as PHN	MRN	
Administrative Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Non-binary/Prefer not to disclose (X) <input type="checkbox"/> Unknown	

All referrals require this form, a **complete referral letter** and **relevant supporting documents**.

Fax each referral individually to **780-644-1743**

- For **acute injuries**, please contact the plastic surgeon on call via **RAAPID North at 1-800-282-9911**
- For **cosmetic referrals**, patients may contact their preferred surgeon directly (*no referral is required*)
- For **hand/wrist conditions**, please complete the FAST Hand/Wrist referral

**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		
<b>Type of Request</b>		
<input type="checkbox"/> Refer to the next available surgeon ( <i>shortest wait time</i> )		
<b>OR</b>		
<input type="checkbox"/> Refer to a specific site or physician ( <i>wait time may be longer</i> )		
Specify site/physician _____		
Breast		
<input type="checkbox"/> Enlarged breasts ( <i>for breast reduction</i> )		
<input type="checkbox"/> Breast asymmetry	<input type="checkbox"/> Gynecomastia	
<input type="checkbox"/> Breast implant complications _____	<input type="checkbox"/> Inverted nipple	
<input type="checkbox"/> Congenital breast deformity	<input type="checkbox"/> Gender-affirming breast surgery	
Craniofacial/Head and Neck		
<b>Deformity</b>		<b>Other</b>
<input type="checkbox"/> Skull ( <i>for cranioplasty</i> )	<input type="checkbox"/> Nose ( <i>reconstruction, rhinoplasty</i> )	<input type="checkbox"/> Excess eyelid skin
<input type="checkbox"/> Orbit	<input type="checkbox"/> Craniofacial bone/soft tissue	<input type="checkbox"/> Eyelid ptosis
<input type="checkbox"/> Post-cancer resection	<input type="checkbox"/> Post-traumatic- location _____	<input type="checkbox"/> Facial asymmetry
<input type="checkbox"/> Ear	<input type="checkbox"/> Eyelid	<input type="checkbox"/> Facial nerve palsy
		<input type="checkbox"/> Osseointegrated implant
Soft Tissue and Skin		
<input type="checkbox"/> Abdominal skin excess <i>(for panniculectomy)</i>	<input type="checkbox"/> Lymphedema	<input type="checkbox"/> Skin/soft tissue mass
<input type="checkbox"/> Chronic wound	<input type="checkbox"/> Massive weight loss/body contouring	<input type="checkbox"/> suspected benign
<input type="checkbox"/> Complex wound	<input type="checkbox"/> Nerve mass	<input type="checkbox"/> suspected malignant
<input type="checkbox"/> Diabetic foot wound	<input type="checkbox"/> Nerve/muscle biopsy	<input type="checkbox"/> Skin cancer
<input type="checkbox"/> Hidradenitis suppurativa	<input type="checkbox"/> Post-burn deformity	<input type="checkbox"/> Squamous cell
<input type="checkbox"/> Hyperhidrosis	<input type="checkbox"/> Scar revision	<input type="checkbox"/> Basal cell
<input type="checkbox"/> Hypertrophic/keloid scar	<input type="checkbox"/> Pressure ulcer/decubitus ulcer	<input type="checkbox"/> Other
Other Condition		
<input type="checkbox"/> _____		