

Facilitated Access to Specialized Treatment (FAST) Adult Otolaryngology Head & Neck Surgery Referral

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

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

Fax each referral individually to **780-644-1790**

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

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	

Referring Physician		
Name		
Phone	PRAC ID	
Referral Information		
Type of Request <i>(choose one)</i>		
<input type="checkbox"/> Refer to the next available surgeon <i>(shortest wait time)</i>		
<input type="checkbox"/> Refer to a specific site or surgeon <i>(wait time may be longer)</i> Specify site/surgeon _____		
<input type="checkbox"/> Otology <i>(* indicates audiogram required)</i>		
<input type="checkbox"/> Sudden hearing loss, urgent within 72hrs *	<input type="checkbox"/> Vertigo *	
<input type="checkbox"/> Hearing loss *	<input type="checkbox"/> Tinnitus *	
<input type="checkbox"/> Chronic otitis media, ear discharge, drainage *	<input type="checkbox"/> Ear FB or lesions	
<input type="checkbox"/> Tympanic membrane perforation *	<input type="checkbox"/> Facial nerve palsy	
<input type="checkbox"/> Ear pain or pressure *	<input type="checkbox"/> Other _____	
<input type="checkbox"/> General Otolaryngology		
<input type="checkbox"/> Recurrent tonsillitis	<input type="checkbox"/> Septal deviation	
<input type="checkbox"/> Recurrent Epistaxis	<input type="checkbox"/> Snoring	
<input type="checkbox"/> Chronic rhinitis / nasal obstruction	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Laryngology and Swallowing Dysfunctions		
<input type="checkbox"/> Chronic Hoarseness	<input type="checkbox"/> Dysphagia	
<input type="checkbox"/> Airway concerns (eg. stenosis, stridor)	<input type="checkbox"/> Zenker's diverticulum	
<input type="checkbox"/> Chronic refractory cough	<input type="checkbox"/> Tracheostomy issues	
<input type="checkbox"/> Professional voice concerns	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Thyroid and Parathyroid		
<input type="checkbox"/> Thyroid mass	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Hyperparathyroidism		
<input type="checkbox"/> Head and Neck		
<input type="checkbox"/> Neck mass	<input type="checkbox"/> Progressive dysphagia	<input type="checkbox"/> Mohs skin defect reconstruction
<input type="checkbox"/> Head and neck cancer	<input type="checkbox"/> Salivary gland masses	<input type="checkbox"/> Chronic Hoarseness
<input type="checkbox"/> Oral and pharyngeal lesion/ulcers/masses	<input type="checkbox"/> Facial lesion/mass	<input type="checkbox"/> Other _____
<input type="checkbox"/> Chronic hoarseness	<input type="checkbox"/> Skin cancer	
<input type="checkbox"/> Rhinology		
<input type="checkbox"/> Sinusitis / sinus disorders	<input type="checkbox"/> Severe complex sinusitis	<input type="checkbox"/> Nasal polyps
<input type="checkbox"/> Chronic sinusitis	<input type="checkbox"/> HHT related epistaxis	<input type="checkbox"/> Nasal CSF leaks
<input type="checkbox"/> Revision sinus surgery	<input type="checkbox"/> Nasal mass	<input type="checkbox"/> Other _____
<input type="checkbox"/> Sleep medicine and surgery		
<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Facial plastic surgery		
<input type="checkbox"/> Nasal deformity, rhinoplasty	<input type="checkbox"/> Facial paralysis	
<input type="checkbox"/> Facial defect	<input type="checkbox"/> Eyelid issues <i>(excessive upper eyelid skin, ptotic brows, ectropion, etc)</i>	
<input type="checkbox"/> Facial trauma/fracture	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Facial scars		