

## Facilitated Access to Specialized Treatment (FAST) Colposcopy Referral

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	

To confirm fax numbers and other clinic information visit [www.albertareferraldirectory.ca](http://www.albertareferraldirectory.ca) and search for FAST Colposcopy

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

TOP website for referral guidelines:

<https://actt.albertadoctors.org/CPGs/Lists/CPGDocumentList/Cervical-Cancer-Screening-CPG.pdf>

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 clinic *(shortest wait time)*

**OR**

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

Specify site/physician \_\_\_\_\_

Re-referral *(this info is **REQUIRED** if patient has been seen in colposcopy prior)*

Previous site and physician \_\_\_\_\_

### Reason for referral

#### Abnormal Cytology

**Higher Risk** *(book within 6 weeks of referral)*

HSIL

ASCH

AGC, AIS, Endometrial cells on a PAP

**Lower Risk** *(book within 6 months of referral)*

ASCUS HPV +

LSIL HPV +

Persistent LSIL

Persistent ASCUS

#### **Suspected Malignancy Requiring Biopsy**

*(book within 2 weeks of referral to Gyn oncologist)*

#### **Referral letter required for triage**

Cervical Cancer

Vulvar Cancer

Vagina Cancer

#### **Other**

#### **Referral letter required for triage**

Clinical Abnormality

See and Treat *(HSIL or AIS on biopsy requiring LEEP)*

Vulvar lesion

Other \_\_\_\_\_