

## Facilitated Access to Specialized Treatment (FAST) Gynecology 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 mandatory information visit:

<https://www.albertahealthservices.ca/assets/info/aph/if-aph-provincial-gynecology-referral-pathway.pdf>

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

Date <i>(dd-Mon-yyyy)</i>	Patient Phone	Alternate Phone	Patient Address	
Current Weight <i>(kg)</i>		Current Height <i>(cm)</i>		BMI
Legal Guardian Name <i>(if applicable)</i>			Phone	Relationship
Referring Provider		Phone	Fax	Prac ID
Clinic Name		Clinic Address		Clinic Fax
Primary Care Provider			Primary Care Provider Contact Information	
<b>Requested Provider</b>				
<input type="checkbox"/> Next Available Provider <b>OR</b> <input type="checkbox"/> Specific Provider _____ <input type="checkbox"/> Location Preference <i>(site/community/zone)</i> _____ <input type="checkbox"/> Previously seen by specialist for the same problem <i>(specify name of specialist)</i> _____				
<b>Referral Requirements</b>				
<input type="checkbox"/> Attach referral letter or complete information on page 2. <i>Include results of mandatory investigations as per Provincial Adult Gynecology Referral Pathway:</i> <a href="https://www.albertahealthservices.ca/assets/info/aph/if-aph-provincial-gynecology-referral-pathway.pdf">https://www.albertahealthservices.ca/assets/info/aph/if-aph-provincial-gynecology-referral-pathway.pdf</a>				
<b>Reason for Referral</b>				
<b>Cervical for Colposcopy</b> <input type="checkbox"/> <a href="#">Cervical Lesion Suspected Benign</a> <input type="checkbox"/> <a href="#">Cervical Lesion Suspected Malignant</a> <b>Abnormal Findings on Pap Smear for Colposcopy</b> <input type="checkbox"/> <a href="#">ASCUS on Pap Smear with Positive HPV Test (ASCUS HPV +)</a> <input type="checkbox"/> <a href="#">ASCUS on Pap Smear (Includes Persistent)</a> <input type="checkbox"/> <a href="#">LSIL on Pap Smear with Positive HPV Test (LSIL HPV +)</a> <input type="checkbox"/> <a href="#">LSIL on Pap Smear (Includes Persistent)</a> <input type="checkbox"/> <a href="#">ASC-H on Pap Smear (ASC-H)</a> <input type="checkbox"/> <a href="#">Atypical Glandular Cells on Pap Smear (AGC)</a> <input type="checkbox"/> <a href="#">HSIL on Pap Smear (HSIL)</a> <input type="checkbox"/> <a href="#">Adenocarcinoma in Situ of Cervix (AIS)</a>			<b>Ovarian</b> <input type="checkbox"/> <a href="#">Adnexal mass</a> <input type="checkbox"/> <a href="#">Management of Primary Ovarian Insufficiency (Premature Ovarian Failure)</a> <input type="checkbox"/> <a href="#">Cancer Risk Reducing Gynecological Surgery</a>	
<b>Menstrual/Uterine Abnormalities</b> <input type="checkbox"/> <a href="#">Abnormal Uterine Bleeding</a> <input type="checkbox"/> <a href="#">Amenorrhea</a> <input type="checkbox"/> <a href="#">Adenomyosis</a> <input type="checkbox"/> <a href="#">Dysmenorrhea</a> <input type="checkbox"/> <a href="#">Oligomenorrhea</a> <input type="checkbox"/> <a href="#">Post Menopausal Bleeding</a> <input type="checkbox"/> <a href="#">Uterine Fibroid</a> <input type="checkbox"/> <a href="#">Uterine Polyp</a>			<b>Genitourinary</b> <input type="checkbox"/> <a href="#">Urinary Incontinence</a> <input type="checkbox"/> <a href="#">Pelvic Organ Prolapse</a> <input type="checkbox"/> <a href="#">Vesico-Urethral Fistula</a> <input type="checkbox"/> <a href="#">Mesh Complications</a> <b>Menopause</b> <input type="checkbox"/> <a href="#">Atrophic Vaginitis</a> <input type="checkbox"/> <a href="#">Vasomotor Symptoms</a>	
<b>Chronic Pain</b> <input type="checkbox"/> <a href="#">Pain in the Pelvis</a> <input type="checkbox"/> <a href="#">Vulvar Pain disorders</a>			<b>Reproductive Health</b> <input type="checkbox"/> <a href="#">Contraception</a> <input type="checkbox"/> <a href="#">Infertility</a> <input type="checkbox"/> <a href="#">Recurrent Pregnancy Loss</a> <b>Transgender Care</b> <input type="checkbox"/> <a href="#">Transgender Care</a> <input type="checkbox"/> <a href="#">Reconstructive Affirming Hysterectomy</a> <input type="checkbox"/> <a href="#">Post Reconstructive Concerns</a>	
			<b>Reason not specified above</b> <i>(provide details)</i>	

