

Facilitated Access to Specialized Treatment (FAST) Non-Urgent Adult Orthopedic & Spine Referral

To confirm fax numbers and other clinic information visit www.albertareferraldirectory.ca and search for Facilitated Access to Specialized Treatment.

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	

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 Primary Phone		Patient Secondary Phone	
Patient Address					
Legal Guardian Name		Phone	Relationship		
Referring Provider		Phone	Fax		PRAC ID
Clinic Address			Primary Care Provider and Contact Info <i>(if available)</i>		
Do you provide specialty care in any of the following areas? <i>(check all that apply)</i>					
<input type="checkbox"/> Orthopedic Surgery		<input type="checkbox"/> Sport Medicine			
<input type="checkbox"/> Physiatry		<input type="checkbox"/> Rheumatology			
<input type="checkbox"/> Neurology		<input type="checkbox"/> Family Medicine working within a multidisciplinary MSK assessment program			
Requested Provider					
<input type="checkbox"/> Next Available Provider		OR		<input type="checkbox"/> Specific Provider _____	
Location Preference _____					
<input type="checkbox"/> Previously seen by the following surgeon for the same problem <i>(specify name)</i> _____					
Referral Requirements					
Attach referral letter OR complete information on bottom of page 2 . Include results of mandatory investigations as per the Provincial Adult Orthopedic & Spine Referral Pathway: https://www.albertahealthservices.ca/assets/info/hp/arp/if-hp-arp-asi-orthopaedics-qr.pdf					
Reason for Referral					
<input type="checkbox"/> Left <input type="checkbox"/> Right		Presumptive Diagnosis <i>(if applicable)</i>			
Dominant Hand <i>(applicable to Shoulder/Elbow/Hand and Wrist Referrals)</i>			<input type="checkbox"/> Left <input type="checkbox"/> Right		
Shoulder <i>(choose one)</i>			Elbow <i>(choose one)</i>		
<input type="checkbox"/> Pain			<input type="checkbox"/> Arthritis		
<input type="checkbox"/> Stiffness			<input type="checkbox"/> Non-degenerative Joint Pathology		
<input type="checkbox"/> Instability			<input type="checkbox"/> Chronic Soft Tissue Pain		
<input type="checkbox"/> Retained Hardware			<input type="checkbox"/> Entrapment Neuropathy		
			<input type="checkbox"/> Mass <i>(tumor or lump)</i>		
			<input type="checkbox"/> Olecranon Bursitis		
Hand and Wrist <i>(choose one)</i>					
<input type="checkbox"/> Arthritis of Hand			<input type="checkbox"/> Pain - Hand		
<input type="checkbox"/> Arthritis of Wrist			<input type="checkbox"/> Pain - Wrist		
<input type="checkbox"/> Carpal Tunnel Syndrome			<input type="checkbox"/> Ligament Pathologies - Hand		
<input type="checkbox"/> Median Nerve Entrapment			<input type="checkbox"/> Ligament Pathologies - Wrist		
<input type="checkbox"/> Radial Nerve Entrapment			<input type="checkbox"/> Tendon Pathologies - Hand & Wrist		
<input type="checkbox"/> Ulnar Nerve Entrapment			<input type="checkbox"/> Mass <i>(tumor or lump)</i>		
			<input type="checkbox"/> Deformity		

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Reason for Referral *(continued)*

Hip *(choose one)*

- | | |
|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bone Deformity <i>(other)</i> |
| <input type="checkbox"/> Symptomatic Hip Arthroplasty | <input type="checkbox"/> Avascular Necrosis (AVN) <i>(without osteoarthritis)</i> |
| <input type="checkbox"/> Pain <i>(without osteoarthritis)</i> | <input type="checkbox"/> Synovial Disorder |
| <input type="checkbox"/> Hip Impingement | <input type="checkbox"/> Residual Childhood Hip Disorder |
| <input type="checkbox"/> Congenital Hip Dysplasia | <input type="checkbox"/> Retained orthopedic Hardware |

Knee *(choose one)*

- Arthritis
- Pain *(without OA)*
- Instability
- Mechanical Symptoms
- Retained Hardware

Foot and Ankle *(choose one)*

- Pain
- Instability
- Swelling
- Deformity
- Ulcer

Injury greater than 4 weeks old *(choose one)*

Acute injuries less than 4 weeks require contacting the on-call surgeon.

- Specify Site _____
- Fracture
- Suspected Tendon Rupture

Spine *(choose one)*

- Radiculopathy *(cervical or lumbar)*
- Neurogenic Claudication
- Myelopathy *(cervical or thoracic)*
- Spinal Deformity
- Back pain *(w/o neurological symptoms)*
- Neck Pain *(without radiculopathy)*

Other *(specify)*

Height (cm)

Weight (kg)

BMI

(check one)

- Referral letter attached **OR** All relevant information is provided below
