

Facilitated Access to Specialized Treatment (FAST) Adult Oral & Maxillofacial Surgery Referral

To confirm fax numbers and other clinic information visit the [Provincial Adult Oral and Maxillofacial Surgery Referral Pathway](#), or www.albertareferraldirectory.ca

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

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	

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"/> Otolaryngology		<input type="checkbox"/> Plastics		<input type="checkbox"/> Dentistry	
Requested Provider					
<input type="checkbox"/> Next Available Provider		OR		<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> _____					
Referral Requirements					
Attach referral letter OR complete information on page 2 . Include results of mandatory investigations as per the Provincial Oral and Maxillofacial Surgery Referral Pathway: https://www.albertahealthservices.ca/assets/info/aph/if-aph-prov-oral-maxillofacial-referral-pathway.pdf					
					
Reason for Referral					
General Oral & Maxillofacial Conditions <i>(choose one)</i>			Suspected Head and Neck Cancer		
<input type="checkbox"/> Chronic TMJ Pain <i>(greater than 3 months)</i>			<input type="checkbox"/> Suspected Head and Neck Cancer		
<input type="checkbox"/> Obstructive Sleep Apnea <i>(for surgical consideration)</i>					
<input type="checkbox"/> Facial Deformity					
<input type="checkbox"/> Cleft Palate					
<input type="checkbox"/> Suspected Benign Mouth and Jaw Lesions					
Other <i>(specify)</i>					
Height (cm)		Weight (kg)		BMI	

