KAMLOOPS EQUALITY HEALTH CENTRE

Referral Form

LGBTQ2S+ and Gender Affirming Care

Fax completed form to: 778-471-6490

Date of referral	**Referring Agency**
PATIENT DETAILS	
Preferred last name:	**Preferred first name:**
Name as it appears on Care Card (if different than above)**:**	Preferred pronouns:
PHN:	DOB Month / Day / Year ☐ **Under 18yrs**
Cell phone:	Sex assigned at birth: ☐ M ☐ F ☐ U ☐ X
Home phone: Message OK? ☐ Yes ☐ No	Gender patient identifies with: (ex. male, female, trans male, trans female, gender fluid, agender)
Street Address: City/Province: Postal Code:	
City/Province:	Postal Code:
PROVIDER INFORMATION	
Referral source	**Primary care provider** (if different from referral source)
Name:	Name:
Clinic Name:	Clinic Name
MSP#	MSP #
REASON FOR REFERRAL	
☐ Primary Care ☐ Hormone assessment/initiation ☐ Continuation of hormone therapy ☐ Surgical assessment/referral	☐ Pre-surgical support ☐ Post-surgical support ☐ Client has a diagnosis of gender dysphoria ☐ Other: _____
MEDICAL HISTORY	
☐ Tobacco/nicotine use ☐ Cannabis/marijuana use ☐ Other substance use	☐ Surgical complications ☐ BMI 35 or above ☐ Sleep apnea CPAP machine ☐ Yes ☐ No ☐ Unk

239 Lansdowne Street, Kamloops, BC V2C 1X8
P: 778-471-4218 F: 778-471-6490

Other past medical history:

Any concerns regarding the stability of physical or mental health? ☐ Yes ☐ No
If yes, please describe:

Surgical history: Please list gender affirming surgery in the next section

For Transgender Patients

Surgical Assessment
- ☐ Scheduled for _____
- ☐ 1st Assessment Done
- ☐ 2nd Assessment Done

On hormone therapy? ☐ No ☐ Yes
If yes, which one? ☐ Feminizing ☐ Masculinizing
Please include hormone therapy in the medication section

Surgical care/planning support required
- ☐ Surgery date (if known)_____
- ☐ Surgical Assessment/Referral
- ☐ Pre-surgical support
- ☐ Post-surgical support

Surgery revisions (describe)
_____
_____

Surgery already performed

Upper surgery
- ☐ Chest surgery and contouring
- ☐ Breast construction surgery
- ☐ Other surgery
  _____
  _____

Lower surgery - Gonadectomy
- ☐ Orchiectomy
- ☐ Hysterectomy/ bilateral salpingo-oophorectomy

Lower surgery – Genital surgery
- ☐ Phalloplasty
- ☐ Metoidioplasty
- ☐ Clitoral release
- ☐ Vulvoplasty
- ☐ Vaginoplasty (includes penectomy, orchiectomy)

Social issues which may impact treatment:

Current medications and allergies: Please include OTC and supplements

Other care providers involved (e.g., specialists, support workers, mental health team)
Please provide name, organization, contact information

Comments/additional information:

PROVIDER SIGNATURE

Provider Name:	**Signature:**	**MSP #:**