

CLINIC USE ONLY

Date Received: _____ DD/MM/YY

Screening Appointment Date: _____ DD/MM/YY

Gender Care Interprofessional Primary Care Team Referral Form

PATIENT INFORMATION

Legal Name: Last First Middle Initial	Chosen Name:	Health Card Number:
Address:	Pronouns:	Date of Birth DD/MM/YY:
	Sex Assigned at Birth: M <input type="checkbox"/> F <input type="checkbox"/>	Mobile Phone: Ok to leave voicemail? Y <input type="checkbox"/> N <input type="checkbox"/>
	Gender:	Home Phone: Ok to leave voicemail? Y <input type="checkbox"/> N <input type="checkbox"/>
Patient Informed of Referral? Yes <input type="checkbox"/> No <input type="checkbox"/>		Patient Consent for Referral Obtained? Yes <input type="checkbox"/> No <input type="checkbox"/>

CLINICAL INFORMATION

Allergies: Yes No *if yes please list

Current Medications: *List attached

Reason for Referral:

Risks (if any):

Is the client attached to any of the following services?

Counselling Services Yes No

Psychiatric Services Yes No

Workplace EAP Yes No

Has the client had any Gender Related Surgeries (GRS)?

Yes No

If yes please list: _____

Has the client started Hormone related therapy?

Yes No

If yes when did they start? DD/MM/YY _____

Primary Care Provider (PCP) Name:	Date:	<p>In order to serve your clients better, the Interprofessional Primary Care (IPC) Team would like to communicate with the PCP during the treatment course.</p> <p>Does the client consent to the CAREA Gender Care IPC Team communicating with referring PCP?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>
Signature:		
Address:	Tel:	
	Fax:	
<input type="checkbox"/> Please attach any relevant clinical reports, consultation notes and results.		

Program Description:

The Gender Care IPC team includes a Nurse Practitioner and Systems Navigator who provide gender transition related care and services within a holistic framework for a time-limited length of service. The team aims to create a safe, confidential, inclusive, and affirming space for trans, gender diverse, gender non-conforming, non-binary and questioning youth and adults in the Durham Region. Specific services include social, legal and medical transition support, hormone therapy, puberty suppression, surgery referral support, advocacy, and health system navigation. We tailor our services to the needs and transition goals of our clients. Clients may retain their primary care providers while seeking gender transition related care from the team and upon completion of goals will be transferred back to their providers.

Inclusion and Exclusion Criteria:

Inclusion Criteria	Exclusion Criteria
<input type="checkbox"/> Geographical location: Client must <u>currently</u> reside in the Durham Region.	<input type="checkbox"/> Actively suicidal and/or poses a high risk to themselves or others. *NOTE: Self harm behaviours are NOT exclusionary.
<input type="checkbox"/> Age: 12yr+	<input type="checkbox"/> Severe impairment in cognitive function (e.g. dementia) that would interfere with informed consent and/or treatment care planning.
<input type="checkbox"/> Self-identify as trans, gender diverse, gender non-conforming, non-binary or questioning.	<input type="checkbox"/> Symptoms of acute mania and/or active psychosis.
<input type="checkbox"/> Seeking gender transition or gender related care services.	<input type="checkbox"/> Problematic use of substances that impacts client's ability to actively participate in their care.
<input type="checkbox"/> Individuals without an OHIP card (uninsured, immigrants, refugees) are accepted.	