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| CLIENT DETAILS | | | | | | | | |
| **Last name:** | **First name:** | | **Middle name:** | | **PHN or UCI\*:** | | | **Pronouns:** |
| **Legal name as appears on CareCard**  **(if different from above):** | | | | | **Date of birth (yyyy-mm-dd):** | | | **Age:** |
| **Mailing address:** | | | | | **Primary phone:** | | | **Message OK?** |
| **City:** | | **Province:** | **Postal code:** | | **Email:** | | | |
| PROVIDER DETAILS | | | | | | | | |
| **Provider name:** | | | **I am the client’s primary care provider** | | | **Billing number:** | | |
| **Mailing address:** | | | | | | **Office phone:** | | |
| **City:** | | **Province:** | **Postal code:** | | | **Office fax:** | | |
| **Please describe your training and experience supporting clients with gender dysphoria:** | | | | | | | | |
| Name of client’s primary care provider: | | | Primary care provider phone: | | | | Primary care provider fax: | |
| **List any other relevant specialists involved in care:** | | | | | | | | |
| CLINICAL INFORMATION | | | | | | | | |
| **Please list the dates you met with client to discuss hormone readiness:**  **Client seen via telehealth? Yes  No** | | | | | | | | |
| 1. **What hormone therapy does the client wish to start (check all that apply)** | | | | | | | | |
| Estrogen based therapy  Testosterone based therapy | | Puberty blockers  Other | |  | | | | |
| 1. **Please describe your client’s gender journey, any history of gender dysphoria, and the impact of any other gender affirming steps taken to date (e.g. , changes in hairstyle or wardrobe, padding/packing/tucking, hair removal, name and/or pronoun change, surgeries):** | | | | | | | | |
| 1. **Has your client previously taken hormones, either through prescription or self-access?** | | | | | | | | |
| 1. **Please summarize your client’s expectations, hopes and any concerns regarding hormone therapy:** | | | | | | | | |
| 1. **Please describe any further gender affirming goals your client may have, either after or concurrently with hormones**   **(e.g., specific surgeries).** | | | | | | | | |
| 1. **Are there any communication or accessibility needs to be aware of? (e.g., interpreter, visual/audio aids, scent-reduced space)**   **Yes  No  If yes please explain:** | | | | | | | | |
| 1. **Please give a brief description of your client’s past and current medical history, including:**   -Physical health: Please list any diagnoses, treatment history and current status  -Mental health: Please list any diagnoses, treatment history and current status  -Age-specific factors for consideration | | | | | | | | |
| 1. **Current medications (attach list if available)** | | | | | | | | |
| 1. **Please indicate if your client has past/current substance use that could impact their ability to start or maintain hormone therapy** | | | | | | | | |
| 1. **Allergies:** | | | | | | | | |
| 1. **Please describe if the WPATH standard is met: “If significant medical or mental health concerns are present, they must be reasonably well controlled.”** | | | | | | | | |
| 1. **Please describe your client’s social situation (housing, work situation, supports)** | | | | | | | | |
| 1. **Are there any physical, mental health or social concerns that need to be addressed prior to or during hormone initiation?** | | | | | | | | |
| 1. **Please describe conversations regarding fertility goals that you have had with your client, including how hormones could potentially impact future fertility, and if applicable, fertility preservation options.** | | | | | | | | |
| **15. Briefly summarize your assessment of the patient and the reasons you are recommending them for hormone therapy.**  **Please comment on: patient’s capacity to consent (Evaluating Decision-Making Capacity for Gender-Affirming Interventions tool can be found here:** [**https://bit.ly/3udyqBs**](https://bit.ly/3udyqBs) **). If your client is under 19 years of age and deemed to be a mature minor according to the BC Infants Act, please provide your rationale for recommending treatment including your assessment of capacity and your clinical rationale related to best interests.** | | | | | | | | |

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| review of proposed treatment(s) | | |
| **The following criteria are applicable to ALL gender affirming procedures: (WPATH Standards of Care)**  I have discussed the potential risks and complications of hormone therapy. This does not replace the prescriber’s informed consent process (if applicable).  I confirm this client understands the information provided and has the capacity to consent to this treatment. If client is under 19 years of age I confirm that in my opinion, they have capacity to consent to treatment and treatment is in their best interest  I confirm this client has persistent, well-documented gender dysphoria. WPATH Standards of Care definition: discomfort or distress that is caused by a discrepancy between a person’s gender identity and that person’s sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)  I confirm this client has no significant medical or mental health concerns OR, if present, these concerns are reasonably well controlled. | | |
| provider signature | | |
| **The above information is true to the best of my knowledge. I am available for coordination of care if needed.** | **Provider signature:** | **Date: (yyyy-mmm-dd)** |

**\***Individuals covered by Interim Federal Health Program (IFHP) will have a Unique Client Identifier (UCI). Providers may apply to be an Approved Provider through IFHP to bill for care delivered to IFHP-covered patients. More information can be found [here](https://docs.medaviebc.ca/providers/guides_info/IFHP-Information-Handbook-for-Health-care-Professionals-April-1-2016.pdf).