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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):**

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| 1. **Has your client previously taken hormones, either through prescription or self-access?**

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| 1. **Please summarize your client’s expectations, hopes and any concerns regarding hormone therapy:**

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| 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)**

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| 1. **Please indicate if your client has past/current substance use that could impact their ability to start or maintain hormone therapy**

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| 1. **Allergies:**

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| 1. **Please describe if the WPATH standard is met: “If significant medical or mental health concerns are present, they must be reasonably well controlled.”**

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| 1. **Please describe your client’s social situation (housing, work situation, supports)**

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| 1. **Are there any physical, mental health or social concerns that need to be addressed prior to or during hormone initiation?**

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| 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.**

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|  **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).