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| CLIENT DETAILS | | | | | | | |
| **Last name:** | **First name:** | | **Middle name:** | **Personal health number:** | | | **Pronouns:** |
| **Name (as appears on BC Services Card):** | | | | **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 | | **Registration number:** | | |
| **Clinical discipline:** | | | | | **Office phone:** | | |
| **Mailing address:** | | | | | **Office fax:** | | |
| **City:** | | **Province:** | **Postal code:** | | **Email address** | | |
| Name of client’s primary care provider (if different): | | | 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 gender-affirming surgery:**  **Client seen via telehealth** | | | | | | | |
| 1. **For which surgery or surgeries are you referring your client (select all that apply):** | | | | | | | |
| *Upper surgery*  Chest reduction & construction (mastectomy & contouring)  Breast construction (augmentation) | | *Lower surgery - Gonadectomy*  Hysterectomy/salpingo-oophorectomy  Orchiectomy | | | *Other surgery:* | | |
| 1. **Please describe your client’s gender identification, their experience of gender incongruence or dysphoria, and the impact of any other gender-affirming steps taken to date (e.g. hormone therapy, hair removal, name change):** | | | | | | | |
| 1. **Has your client taken hormones? If so, when did they start and who is prescribing?** | | | | | | | |
| 1. **Summarize your patient’s expectations regarding surgery:** | | | | | | | |
| 1. **Are there any communication or accessibility needs that the surgeon needs to be aware of? (e.g., interpreter, visual/audio aids)** | | | | | | | |
| 1. **Provide a brief description of your client’s past and current medical history, including:** | | | | | | | |
| 1. **Physical health:** List any diagnoses, treatment history and current status     **Height:**      **Weight:**       **BMI:**       **Sleep apnea**  **Yes  No** | | | | | | | |
| 1. **Mental health** List any diagnoses, treatment history and current status | | | | | | | |
| 1. **Surgical history:** | | | | | | | |
| 1. **Current medications (attach list if available):** | | | | | | | |
| 1. **Please indicate if your client has past/current substance use that would affect their peri-operative experience.**   **Yes** **No If yes, please describe:** | | | | | | | |
| **f. Allergies:** | | | | | | | |
| 1. **Describe your client’s social situation (housing, work, supports):** | | | | | | | |
| 1. **Do you anticipate your client will have stable housing and adequate support to facilitate healing during the post-op period?** | | | | | | | |
| 1. **Do you believe your client is capable of carrying out their after care plan? (e.g, reducing activities, managing drains/compression vest, etc.)?** **Yes** **No If no, please explain how this will be managed:** | | | | | | | |
| 1. **Briefly summarize your conversation with the patient regarding impacts to fertility (gonadectomy procedures):** | | | | | | | |
| 1. **Briefly summarize your recommendation:** | | | | | | | |
| REVIEW OF WPATH Standards of Care 8 criteria | | | | | | | |
| **The following criteria are applicable to ALL gender-affirming procedures:**  I confirm that I have reviewed with the client the following procedure(s) noted above.  I confirm this client’s gender incongruence/gender dysphoria is marked and sustained.  I confirm the client meets diagnostic criteria for gender incongruence/gender dysphoria and have excluded other possible causes of apparent incongruence.  I confirm this client understands the information provided and has the capacity to consent to the treatment(s) outlined above. 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 that any mental health and physical conditions that could negatively affect the outcome of treatment for this client have been assessed, with risks and benefits discussed.  I confirm that the client understands the impact of treatment on reproduction and/or infant feeding and have reviewed relevant options.  *As part of the assessment for gender-affirming hormonal or surgical treatment, professionals should consider the role of social transition together with the individual. WPATH recommends that providers assessing individuals who have a change in gender goals (ie: de-transition) and are seeking hormone and/or surgical intervention utilize a comprehensive multidisciplinary assessment that includes additional viewpoints from experienced health care professionals in transgender health and that considers, together with the individual, the role of social transition as part of the assessment process.* | | | | | | | |

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| CONFIRMATION OF Qualifications | | |
| Clinicians supporting clients with decisions regarding gender-affirming medical or surgical treatments should hold specific qualifications and competencies to assess readiness for gender-affirming surgeries. WPATH SOC-8 suggests providers liaise with professionals from different disciplines for consultation and referral, when required.  I confirm that I hold the following qualifications and competencies:   * I have a Master’s degree or equivalent training in a clinical field relevant to this role * I am licensed by a statutory body * I am able to identify mental health or psychosocial concerns and distinguish these from gender incongruence, dysphoria or diversity * I am able to assess capacity to consent * I have experience or am qualified to assess clinical aspects of gender incongruence, dysphoria and diversity * I engage in ongoing professional development relating to gender incongruence, dysphoria and diversity.   I confirm that I hold the following additional competencies for working with youth (if relevant):   * I have theoretical and evidenced-based training and expertise in general child, adolescent, and family mental health across the developmental spectrum. * I have training and expertise in gender identity development, gender diversity in children and adolescents and possess general knowledge of gender diversity across the life span. * I have training and experience in autism spectrum disorders and other neurodevelopmental presentations or I collaborate with a developmental disability expert when working with autistic/neurodivergent gender diverse adolescents. * I engage in ongoing professional development in all areas relevant to gender diverse children, adolescents, and families.   **Select one:**  I am competent using ICD (or alternative) to diagnose gender incongruence/gender dysphoria.   * *A diagnosis of gender incongruence/dysphoria is required prior to gender-affirming medical or surgical treatments.* * *Any physician or nurse practitioner is qualified to makes these diagnoses although some may feel they lack relevant training and experience.*   **OR**  I am a clinician whose scope of practice does not include the ability to diagnose gender incongruence or dysphoria. However, I have experience care planning for clients seeking gender-affirming medical or surgical interventions and providing recommendations for treatment. If needed, I will assist my client in connecting with a clinician who is qualified to diagnose gender incongruence or dysphoria. | | |
| Clinician signature | | |
| The above information is true to the best of my knowledge. I am available for coordination of care if needed. | **Clinician signature:**  \_\_\_\_\_\_\_\_\_\_\_\_ | **Date: *(yyyy-mmm-dd)*** |