|  |  |
| --- | --- |
| **TCBC OFFICE USE ONLY** | **Surgeon assigned:** |
|  **Referral Priority DATE (YYYY-MMM-DD)** |  |
| **PATIENT INFORMATION** |
| **Last name:**   | **Name Used:**  |
| Name (as appears on BC Services Card):   | Pronouns:  |
| PHN:  | Date of birth (yyyy-mmm-dd):       | [ ]  **Under 18yrs?** |
| Address:      |
| City:  | Province:  | Postal Code: |
| Phone:  | Message ok? [ ] Yes [ ] No | Email:  |
| ***Any considerations regarding appointment booking?*** |       |
| **REFERRAL DETAILS** |
| **Refer To***(select only one)* | [ ]  Next available surgeon **within region**: [ ] *Vancouver* [ ]  *Fraser* [ ]  *Island* [ ] *Interior* [ ]  *North*[ ]  Next available surgeon, *at any location*  |
| [ ]  Specific Surgeon(s): *(see next page for list)* | **Dr.**  |
| **Reason for Referral** | [ ]  Chest construction (mastectomy & contouring) | [ ]  Breast construction (augmentation) |
| [ ]  Chest reduction [ ]  Revisions (describe):        | [ ]  Other (describe):   |
| **Surgical Care Planning Recommendation** | [ ]  Completed surgical recommendation is attached **OR**[ ]  Please coordinate a surgical care planning appointment for this patient.* *Have you or any other provider confirmed a diagnosis of gender incongruence/gender dysphoria for this patient*? [ ] Yes [ ] No
 |
| **REQUIRED:** | **BMI:**        | [ ]  **Sleep apnea** – CPAP machine? [ ] Yes [ ] No |
| **Any concerns regarding the stability of your patient’s physical or mental health?**  | [ ]  No  | [ ]  Yes, **SEE ATTACHED** |
| **Any medical or surgical history?**  | [ ]  No | [ ]  Yes, **SEE ATTACHED** |
| **Any current medications and/or allergies?** | [ ]  No | [ ]  Yes, **SEE ATTACHED** |
| **Any psycho-social concerns that may impact treatment?** | [ ]  No | [ ]  Yes, **SEE ATTACHED** |
| **Any substance use (including tobacco, cannabis, other)?** | [ ]  No | [ ]  Yes, **SEE ATTACHED** |
| **A history of physical or verbal aggression?**  | [ ]  No  | [ ]  Yes, **SEE ATTACHED** |
| **Referrals for breast construction only: Length of time on hormone therapy:** |  |  |
| **REFERRING PROVIDER (must be physician or NP)** |
| Name:  | MSP Billing #:  | Office Address: *- If available, place office information Label or Stamp -* |
| **Primary Care Provider** (if different): | Phone:  |
| Fax:  |
| **Signature:** | **Date (yyyy-mmm-dd):** |

**INSTRUCTIONS**

Surgeons require a copy of the surgical recommendation in addition to this referral form. **Trans Care BC will only forward the complete referral package to the surgeon’s office AFTER the surgical recommendation has been received.**

1. **Complete form** **and select surgeon** in collaboration with your patient**.**
2. **Include the following information:**

 [ ]  current BMI [ ]  medical history [ ]  completed surgical recommendation (if available)

1. **Trans Care BC will send a receipt** to the referring provider within 10 business days.
2. **Trans Care BC will contact the patient** to confirm surgeon choice and forward complete referral package.
3. **Surgeon’s office will** contact patient or referring provider to set up an appointment.
4. **Referring or primary care provider** (if different) to support post-operative care.

**SURGEONS** **WORKING FROM THE CENTRALIZED WAIT LIST**

* Surgeon profiles available at: <http://www.phsa.ca/transcarebc/surgery/how-to-get-surgery/surgeons>
	+ These surgeons work collectively from a shared central waitlist. To ensure equity in access, referrals must be sent via the Trans Care BC central waitlist.

**IMPORTANT NOTES REGARDING BREAST CONSTRUCTION (BREAST AUGMENTATION)**

* Breast construction is publicly-funded only under certain circumstances. A plastic surgeon must submit a funding application to MSP prior to surgery.