|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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.