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|  **Referral Date (YYYY-MMM-DD)** |
| **PATIENT INFORMATION** |
| **Last name:**   | **First name:**  |
| 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:  |
| Primary language:       | Interpreter required? [ ] Yes [ ] No |
| Emergency contact name:       | Emergency contact phone:       |
| ***Any considerations regarding appointment booking?*** |       |
| **REFERRAL DETAILS**  |
| **Have you or any other provider confirmed a diagnosis of gender incongruence or dysphoria?:** [ ] Yes [ ] No*Note: for advice regarding diagnosis, consult RACE Line/eCASE*  |
| **Surgery type(s)** Select all that apply |  |
| **GENITAL SURGERY**Surgical care planning needs to be done by a provider on Trans Care BC’s list of approved clinicians  | **GONADECTOMY & UPPER SURGERY**Surgical care planning can be done by providers who meet the competencies outlined in the WPATH SOC 8. See Trans Care BC’s website for details.  |
| ***Genital surgery***[ ]  Vaginoplasty (full depth) or vaginoplasty (minimal depth) or vulvoplasty[ ]  Phalloplasty, metoidioplasty & erectile tissue (clitoral) release | ***Gonadectomy***[ ]  Hysterectomy/ salpingo-oophorectomy[ ]  Orchiectomy |
| ***Upper surgery***[ ]  Chest reduction & construction (mastectomy & contouring)[ ]  Breast construction (augmentation) |
| **Surgery date (if known):**       |
| **MEDICAL HISTORY** |
| **Past medical history:** |
| Please select any of the following that apply to your client: |
| **BMI:**       | [ ]  **Sleep apnea**CPAP machine? [ ] Yes [ ] No | [ ]  Tobacco/nicotine use[ ]  Cannabis/marijuana use [ ]  Other substance use |

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| **Do you have any concerns regarding the stability of your patient’s physical or mental health?** [ ]  Yes [ ]  NoIf yes, please describe:  |
| **Surgical history** |
| **Current medications and/or allergies****Duration of time on hormone therapy, if applicable:** | [ ]  List attached |
| **Psycho-social concerns that may impact treatment** | [ ]  No concerns |
| **Does your client have a history of physical or verbal aggression?**  | [ ]  Yes [ ]  No |
| **Other Care Providers involved (e.g. specialists, support workers, mental health team)****Name(s), Organization, Phone number** |
| **REFERRING PROVIDER (must be Physician or NP)** |
| Referring Provider Name:  | Office Address: *- If available, place office information Label or Stamp -* |
| **Signature** | **Date (yyyy-mmm-dd):** |
| **Name of Primary Care Provider** (if different from above): | Primary Care Provider Contact information: |

 **INSTRUCTIONS**

1. **Complete this form** and select type(s) of surgery applicable to the surgical care planning.
2. **Trans Care BC will contact the patient to book the appointment.**
3. **Trans Care BC will forward completed surgical care plan to referring provider** (and primary care provider if different).
4. **Provider to refer patient for surgery.** Trans Care BC cannot refer a patient for surgery. More information here: <http://www.phsa.ca/transcarebc/health-professionals/med-forms>
	* **Upper surgery:** Refer to the Trans Care BC Central Waitlist for upper surgeries.

Referral form available here: <http://www.phsa.ca/transcarebc/health-professionals/med-forms>

* + - Under the Surgery Referral heading, select either ‘Chest construction’ or ‘Breast construction’ > Select ‘Referral Form for Upper Surgery’
	+ **Gonadectomy:** Refer directly to surgeon
	+ **Genital surgery:** Refer directly to surgical centre
		- * **Gender Surgery Program BC (GSPBC):** refer directly for any genital surgery
				1. <http://www.vch.ca/locations-services/result?res_id=1457> under Referral and Surgical Journey
			* **GRS Montreal:** refer directly (vulvoplasty & vaginoplasty are the only publicly-funded surgeries available to BC residents at this clinic)
				1. <https://www.grsmontreal.com/>