LOWER SURGERY REFERRAL FORM

DIAMOND HEALTH CARE CENTRE, VANCOUVER GENERAL HOSPITAL

To be completed by Primary Care Provider. Please complete the fields below as thoroughly as possible.
Fax completed form to: 604-875-5075

Date of referral (YYYY-MM-DD): ____________________

CLIENT DETAILS

Last name: ____________________ **First name:** ____________________

Legal name (as appears on CareCard): ____________________ Pronouns: ____________________

PHN: ____________________ Date of birth (YYYY-MM-DD): ____________________ ☐ **Under 18yrs?**

Address: ____________________ City: ____________________

Province: ____________ Postal Code: ____________ Email: ____________________

Primary Phone: ____________________ Ok to leave message? ☐ Yes ☐ No

Phone Type: ☐ Home ☐ Work ☐ Cell ☐ Other

Alternate Phone: ____________________ Ok to leave message? ☐ Yes ☐ No

Phone Type: ☐ Home ☐ Work ☐ Cell ☐ Other

Primary Language: ____________________ Interpreter required? ☐ Yes ☐ No

PROVIDER INFORMATION

Referring Physician Name: ____________________

Address: ____________________

Role: ____________________ Phone: ____________________ Fax: ____________________

Primary Care Provider (if different from referring physician): ____________________

Address: ____________________

Role: ____________________ Phone: ____________________ Fax: ____________________

REFERRAL DETAILS

1. ELIGIBILITY CRITERIA. Has the patient:

☐ Completed all required surgical readiness assessments **(PLEASE ATTACH)**

Assessment 1 Date and Assessor Name: (YYYY-MM-DD) ____________________

Assessment 2 Date and Assessor Name: (YYYY-MM-DD) ____________________

2. Past Medical History

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3. Medication

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PATIENT NAME: ______________________________

4. **Duration of masculinizing/feminizing hormones**

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5. **Smoking Status:** ☐ Smoker ☐ Non-Smoker

6. **Has the patient had lower masculinizing/ feminizing surgery before?** ☐ No ☐ Yes (YYYY-MM-DD) __________
Please describe: ______________________________

7. **Does the patient currently have an appointment booked for lower masculinizing/ feminizing surgery either Out Of Province or Out Of Country?** ☐ No ☐ Yes; **Surgery date** (if known) (YYYY-MM-DD) __________

8. **Type of surgery requested:**
☐ Phalloplasty ☐ Metaoidioplasty ☐ Clitoral release ☐ Vaginoplasty ☐ Vulvoplasty ☐ Orchiectomy
☐ Testicular or Penile Implants ☐ Surgery revisions (describe): ______________________________

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9. **Do you have any concerns regarding the stability of your patient's physical or mental health?**
☐ No ☐ Yes; Please describe: ______________________________

10. **Comments/additional information:**

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PROVIDER SIGNATURE

Provider Name: ______________ **Signature:** ______________ **Date (yyyy-mmm-dd):** __________

Please attach completed assessment letters and Fax to:
604-875-5075