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| CLIENT DETAILS | | | | | | | | |
| **Last name:** | **First name:** | | **Middle name:** | | **Personal health number:** | | | **Pronouns:** |
| **Legal name as appears on CareCard**  **(if different from above):** | | | | | **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 | | | **Billing number:** | | |
| **Mailing address:** | | | | | | **Office phone:** | | |
| **City:** | | **Province:** | **Postal code:** | | | **Office fax:** | | |
| **Please describe your training and experience supporting clients with gender dysphoria:** | | | | | | | | |
| Name of client’s primary care provider: | | | 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:** | | | | | | | | |
| *Upper surgery*  Chest surgery and contouring  Breast augmentation surgery | | *Lower surgery - Gonadectomy*  Hysterectomy/bilateral salpingo-oophorectomy  Orchiectomy | | *Lower Surgery - Genital Surgery*  Vaginoplasty (includes penectomy, orchiectomy)  Phalloplasty  Metoidioplasty  Clitoral release  Vulvoplasty | | | | |
| *Other surgery:*  *Surgery revisions:* | | | |
| 1. **Please describe your client’s gender identification, their history of gender 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. **Please summarize your patient’s expectations regarding surgery:** | | | | | | | | |

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| 1. **If applicable, please describe how your client has met the requirement for one continuous year of living congruently with their gender identity:** |
| 1. **Are there any communication or accessibility needs that the surgeon needs to be aware of? (e.g., interpreter, visual/audio aids)** |
| 1. **Please give a brief description of your client’s past and current medical history, including:**   **Physical health:** Please list any diagnoses, treatment history and current status    **Height:**      **Weight:**       **BMI:**       **Sleep apnea**  **Yes  No** |
| **Mental health** Please list any diagnoses, treatment history and current status |
| **Surgical history:** |
| **Current medications (attach list if available):** |
| **Please indicate if your client has past/current substance use that would impact on their peri-operative experience.**  **Yes** **No If yes, please describe:** |
| **Allergies:** |
| 1. **Please describe if the WPATH standard is met:**   **Upper surgery: “If significant medical or mental health concerns are present, they must be *reasonably* well controlled.”**  **Lower surgery: “If significant medical or mental health concerns are present, they must be well controlled.”**  **Comments**: |
| 1. **Please describe your client’s social situation (housing, work situation, 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, managing dilations, etc.)?** **Yes** **No If no, please explain how this will be managed:** |

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| 1. **Briefly summarize your assessment of the patient and the reasons you are recommending them for surgery:** |

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| informed CONSENT | | | |
| **The following criteria are applicable to ALL gender affirming procedures: (WPATH Standards of Care 7)**  I confirm that I have reviewed with the client the following procedure(s): \_\_\_\_\_\_\_\_\_\_\_\_  I have discussed the potential risks and complications, including after care and typical post-operative recovery timeline. *This does not replace the surgeon’s informed consent process.*  I confirm this client understands the information provided and has the capacity to consent to this treatment.  I confirm this client has persistent, well-documented gender dysphoria. *Standards of Care 7 definition: discomfort or distress that is caused by a discrepancy between a person’s gender identity and that person’s sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics)*[[1]](#footnote-1)  I confirm my client is at least 19 years or if under 19 years they have:  Parental/caregiver support  Deemed to be a mature minor as defined in the *British Columbia Infants Act*.[[2]](#footnote-2)  I feel the benefits of proceeding without parental consent outweigh any potential risks. | | | |
| ***Select Category:*** | ***In addition to the criteria above, the client must meet the following criteria for the category of procedure(s):*** | | |
| **Upper – chest or breast surgery** | I confirm this client has no significant medical or mental health concerns OR, if present, these concerns are *reasonably* well controlled. | | |
| **Lower - Gonadectomy** | I confirm that the client understands that this intervention results in permanent infertility.  I confirm this client has no significant medical or mental health concerns OR, if present, these concerns are *well controlled*.  I confirm this client has completed 12 continuous months of hormone therapy as appropriate to the client’s gender goals (unless hormones are not clinically indicated for the client). | | |
| **Lower – Genital surgery** | I confirm that the client understands that this intervention results in permanent infertility.  I confirm this client has no significant medical or mental health concerns OR, if present, these concerns are *well controlled*.  I confirm this client has completed 12 continuous months of hormone therapy as appropriate to the client’s gender goals (unless hormones are not clinically indicated for the client)  I confirm this client has 12 continuous months of living in a gender role congruent with their gender identity. | | |
| provider signature | | | |
| The above information is true to the best of my knowledge. I am available for coordination of care if needed. | | **Provider signature:**  \_\_\_\_\_\_\_\_\_\_\_\_ | **Date: *(yyyy-mmm-dd)*** |

1. Fisk,1974; Knudson, De Cuypers, & Bockting, 2010b [↑](#footnote-ref-1)
2. BC Infants Act, Medical treatment for mature minors (under the age of 19) can be provided in the absence of parental consent if a) health provider has explained the treatment options to the adolescent and is satisfied the adolescent “understand the nature and consequences and the reasonably foreseeable benefits and risks”, (b) the health care provider has made “reasonable efforts to determine and has concluded that the health care is in the infant’s best interests,” and (c) the patient has provided consent. [↑](#footnote-ref-2)