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| [ ]  Fax completed form to the primary care provider listed. [ ]  Primary Care MOA: attach to referral for surgeon Dr:       |
| 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:       |
| ASSESSMENT PROVIDER DETAILS |
| **Provider name:**       | **Billing number:**       |
| **Mailing address:**       | **Office phone:**       |
| **City:**       | **Province:**       | **Postal code:**       | **Office fax:**       |
| **Please describe your training and experience supporting clients with gender dysphoria:** . |
| **Please list the date(s) you met with client to discuss gender affirming surgery:**            | **[ ]  I was present with this client at the same visit as (name of first provider):**       **[ ]  Client seen via telehealth**  |
| PRIMARY CARE PROVIDER |
| Name of client’s primary care provider:      | Primary care provider phone:        | Primary care provider fax:       |
| ASSESSMENT SUMMARY |
| 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 reviewed the clinical documentation from the first surgical readiness assessment provided by (name of first provider):[ ]  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. |
| Comments/Notes |
| **Choose one:** [ ]  **I agree with the surgical recommendation**  [ ]  **I disagree with the surgical recommendation** |
| 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)