Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Eligibility: The TSC program provides services to people 15 and older living in the Vancouver Coastal Health region. If you have questions regarding program eligibility, please email: transcareintake@vch.ca

Trans Specialty Care
Referral for Surgical Care Planning
(Fax to 604-844-2223)

Referral Date:		
PATIENT INFORMATION		
Last name:	**First name:**	
Legal name (as appears on CareCard):	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

Surgery type(s): Select all that apply

GENITAL SURGERY	**GONADECTOMY & UPPER SURGERY**
Surgical care planning needs to be done by a provider on Trans Care BC's list of approved clinicians	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)

Hormone start date (if known):

Patients require both a recommendation and a referral to access surgery. Will you as the referring provider ALSO refer to the surgeon? ☐ Yes ☐ No

If yes, then we will return the completed recommendation back to you to include with your referral to the surgeon. Information about how to refer for different surgeries can be found on Trans Care BC's website here:
http://www.phsa.ca/transcarebc/health-professionals/med-forms

MEDICAL HISTORY (Alternatively please include EMR Medical Summary)

Past medical history:

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TSC Referral for Surgical Care

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
Do you have any concerns regarding the stability of your patient's physical or mental health? ☐ Yes ☐ No If yes, please describe:		
Surgical history		
Current medications and/or allergies		☐ List attached
Psycho-social concerns that may impact surgical recovery		☐ No concerns
Does your client have a history of physical or verbal aggression? (If yes, please describe)		☐ Yes ☐ No
Other Care Providers involved (e.g. Primary Care Provider, specialists, support workers, mental health team) Name(s), Organization, Phone number		

REFERRING PROVIDER (must be Physician or NP)	
Referring Provider Name:	Office Address (stamp):
Signature:	**Date (yyyy-mmm-dd):**
Primary Care Provider (if different than above):	Primary Care Provider contact information: