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: _____ ☐ consent to 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) _____

2. Past Medical History

_____

_____

_____

3. Medication

_____

_____

_____

PATIENT NAME: _____

4. Duration of masculinizing/feminizing hormones

_____

_____

_____

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 ☐ Metoidioplasty ☐ **Erectile Tissue release** ☐ Vaginoplasty ☐ Vulvoplasty

☐ Testicular or Penile Implants ☐ Surgery revisions (describe): _____

_____

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:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PROVIDER SIGNATURE

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

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