

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

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 Metaoidioplasty Clitoral release Vaginoplasty Vulvoplasty Orchiectomy
 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**