

PATIENT INFORMATION
 (Affix Patient Label/Identification Here)

Name in use: _____
 Legal name: _____ Date of Birth: ____ / ____ / ____
 Health Card: _____ Version Code: _____
 Address: _____
 Telephone: _____ Alternate: _____

SURGICAL SERVICES TRANSITION RELATED SURGERY (TRS) PROGRAM COVER PAGE

PLEASE SUBMIT THIS COVER PAGE WITH YOUR REFERRAL

PLEASE SEE OUR WEBSITE FOR MORE INFORMATION ON WHAT SERVICES ARE PROVIDED AND HOW TO MAKE A REFERRAL

Referral Date: ____ / ____ / ____ Specific Surgeon? No (first available)
 DD/MM/YYYY Yes (Dr. _____)

PATIENT INFORMATION

Name in use: _____ Gender identity: _____
 Pronouns: He, Him She, Her They, Them Other: _____ Sex assigned at birth: Male Female
 Insurance coverage: OHIP Other: _____ Interpreter required: Yes No
 Allergies: _____ Language spoken: _____

REFERRING PROVIDER INFORMATION

Name: _____ Billing number: _____
 Address: _____
 Telephone: _____ Signature: _____
 Fax: _____
 Alternate report sent to: _____

REASON FOR REFERRAL

Surgical consult for:
Dr. Y. Krakowsky **Dr. M. Brown /Dr. B. Beber /Dr. J. Semple** **Dr. L. Allen**
 Orchiectomy Chest Masculinization (Mastectomy with contouring) Bilateral Salpingo-Oophorectomy
 Scrotectomy Breast Augmentation Hysterectomy
 Penile Inversion Vaginoplasty
 Post-operative Surgical Complication: _____
 Other: _____
 Date of original surgery: _____ by Dr. _____
 MoHLTC prior approval form submitted: Yes No If no, please explain: _____

FAMILY AND MEDICAL HISTORY

<p>Past and current medical history: Providers involved in patient's care: _____ _____ Hormonal therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No since: _____ Substance use: _____ Smoker: <input type="checkbox"/> Yes <input type="checkbox"/> No BMI: _____</p>	<p>Ensure the following is included (or risk having referral rejected): <input type="checkbox"/> Comprehensive referral including medical history pertinent to proposed surgery and/or anesthesia risk <input type="checkbox"/> Gender history and surgical goals <input type="checkbox"/> MoHLTC prior approval <u>confirmation letter</u> (unless previously discussed) <input type="checkbox"/> Medication list</p>
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This cover page is not considered a referral.

Additional information/comments:

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