WCHH
WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED

76 Grenville Street
Toronto, Ontario M5S 1B2
Telephone: 416-323-6307
Fax: 416-323-6310

SURGICAL SERVICES TRANSITION RELATED SURGERY (TRS) PROGRAM REFERRAL FORM

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

Name in use: _____

Legal name: _____ Date of Birth: ___/___/____ DD/MM/YYYY

Health Card: _____ Version Code: _____

Address: _____

Telephone: _____ Alternate: _____

Referral Date: ___/___/____ DD/MM/YYYY

Specific Physician? ❑ No (first available)
❑ Yes (Dr. _____)

PATIENT INFORMATION

Name in use: _____
Pronouns: ❑ He, Him ❑ She, Her ❑ They, Them Other: _____
Insurance coverage: (OHIP, IFH, UHIP, other)
Language spoken: _____
Allergies: _____

Gender identity: _____
Sex assigned at birth: ❑ Male ❑ Female
Self-pay: ❑ Yes ❑ No
Interpreter required: ❑ Yes ❑ No

REFERRING PROVIDER INFORMATION

Name:
Address:
Telephone:
Fax:
Alternate report sent to:

Billing number: _____

Signature:_____

REASON FOR REFERRAL

Surgical consult for:

Dr. Y. Krakowsky
❑ Orchiectomy
❑ Scrotectomy
❑ Testicular/Penile implant

Dr. J. Semple /Dr. B. Beber /Dr. M. Brown
❑ Mastectomy
❑ Chest Contouring
❑ Breast Augmentation

Dr. L. Allen
❑ Bilateral Salpingo-Oophorectomy
❑ Hysterectomy

❑ 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

Past and current medical history:
Providers involved in patient's care:
_____
Gender dysphoria diagnosis made: ❑Yes ❑No
by Dr/NP: _____
Hormonal therapy: ❑ Yes ❑ No since: _____
Living in current gender role since: _____
Mental health: _____
Substance use: _____
Smoker: ❑ Yes ❑ No
BMI: _____

Ensure the following is included (or risk having referral rejected):
❑ Comprehensive referral including medical history pertinent to proposed surgery and/or anesthesia risk
❑ If not included in referral note: pre-surgical planning visit notes
  ❑ Upper Surgeries – 1 provider necessary
  ❑ Lower Surgeries – 2 providers necessary
❑ MoHLTC prior approval confirmation letter (unless previously discussed)
❑ Previous TRS surgery notes (if applicable)
❑ Medication list

Additional information/comments: