WCH
WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED

76 Grenville Street
Toronto, Ontario M5S 1B2
Telephone: 416-323-6400
Ext. 6148
Fax: 416-323-6310

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: _____

SURGICAL SERVICES TRANSITION RELATED SURGERY (TRS) PROGRAM COVER PAGE

PLEASE SUBMIT THIS COVER PAGE WITH YOUR REFERRAL / LETTERS

MAKING A REFERRAL

Before making a referral, please ensure that you have provided the patient with comprehensive transition related surgery planning visit(s) and that the patient meets OHIP eligibility for surgery (unless contraindicated).

To make a **complete** referral please submit **ALL** of the following:

1) WCH Surgical Services Transition Related Surgery Program Cover Page
2) a. a comprehensive referral letter including medical history pertinent to proposed surgery and anesthesia risk
   OR
   b. a brief referral letter including your pre-surgical planning visit notes
   [Please see our website on components of comprehensive referral letter https://www.womenscollegehospital.ca/care-programs/surgery/]
3) OHIP Surgery Funding approval letter

If you are unsure of what a comprehensive referral letter involves, please see **Comprehensive WCH Referral Template** on our website for additional information.

Please fax all pages of the required documents to **416-323-6310**. Once the referral is received, it will be assessed by someone from the TRS team. If incomplete, it will be returned by fax requesting the missing information. If the referral is complete, it will be sent to the appropriate surgeon's secretary and your patient will be contacted with the next available appointment.

The surgical team of the Transition-Related Surgery (TRS) program includes specialists in plastic surgery, urology, gynecology, anesthesiology, and psychiatry as well as nurse practitioners, nurses, physiotherapists and other health care providers. Please note that a referral may be seen by any of the health disciplines previously mentioned. Please inform your patient that, if appropriate, their care may include different members of this TRS team.

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

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

(Please see our website: *https://www.womenscollegehospital.ca/care-programs/ surgery/transition-related-surgeries/)*

PATIENT INFORMATION

Preferred Name: _____ Gender: _____

Pronouns: ❑He/Him ❑She/Her ❑They/Them ❑ Other:_____ Sex assigned at birth: ❑ Male ❑ Female

Insurance coverage: ❑ OHIP Other: _____ Interpreter required: ❑ Yes ❑ No

Language spoken: _____

Allergies: _____

REFERRING PROVIDER INFORMATION

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

Billing number: _____

Signature:_____

REASON FOR REFERRAL

Surgical consult for:

❑ Orchiectomy
❑ Scrotectomy
❑ Penile Inversion Vaginoplasty
❑ Chest Masculinization (Mastectomy with contouring)
❑ Breast Augmentation
❑ Bilateral Salpingo-Oophorectomy
❑ Hysterectomy
❑ Post-operative Surgical Complication: _____

Other: _____

Date of original surgery: _____ by Dr. _____

MOHLTC approved funding letter attached? ❑ Yes Only accepting referrals with APPROVED funding letter attached

FAMILY AND MEDICAL HISTORY

Past and current medical history:

OHIP Funding support letters by:

1) Dr/NP/Other _____

2) Dr/NP/Other _____

Hormone therapy: ❑ Yes ❑ No Since: _____

Mental health: _____

Smoker:: ❑ Yes ❑ No

BMI: _____

Anesthesia risks identified?: _____

Ensure the following is included (or risk having referral rejected): *See our program website for how to make a referral*

❑ TRS program cover page

❑ Comprehensive referral including medical history pertinent to proposed surgery and anesthesia risk

OR

❑ A brief referral letter including your pre-surgical planning visit notes

❑ OHIP Surgery Funding approval letter

❑ Patient aware of and consents to TRS team based care

Additional information/comments: