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.

This fax transmission contains confidential information that is intended only for the Women’s College Hospital clinics. If you are not the intended recipient, you are hereby notified that any disclosure, copying or distribution of the contents of this fax is strictly prohibited. If you have received this fax transmission in error, please immediately notify the referring health practitioner at the telephone number provided above to arrange for the return or destruction of this document.
SURGICAL SERVICES TRANSITION RELATED SURGERY (TRS) PROGRAM COVER PAGE

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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: ____________________________
Insurance coverage: □ OHIP □ Other: ____________________________
Language spoken: ____________________________
Allergies: ____________________________

REFERRING PROVIDER INFORMATION

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

REASON FOR REFERRAL

Surgical consult for:
□ Orchiectomy □ Chest Masculinization (Mastectomy with contouring)
□ Scrotectomy □ Bilateral Salpingo-Oophorectomy
□ Penile Inversion Vaginoplasty □ 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:

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