WCHI
WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED

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SURGICAL SERVICES TRANSITION RELATED SURGERY (TRS) PROGRAM COVER PAGE

PLEASE SUBMIT THIS COVER PAGE WITH YOUR REFERRAL

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

PATIENT INFORMATION

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

Gender identity: _____
Sex assigned at birth: ❑ Male ❑ Female
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
❑ Penile Inversion Vaginoplasty

Dr. Brown /Dr. Semple
❑ Chest Masculinization (Mastectomy with 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 Only accepting surgery patients if OHIP submitted with referral

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): See our program website for how to make a referral

❑ 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
Previous TRS surgery notes (if applicable)
❑ Medication list

Additional information/comments: