**Referral Template**

**Your profession:**

**Your experience in completing assessments for gender related surgery:**

**Gender identity:**

**Please give a description of this client:**

**Other identifying characteristics (Age, Ethnicity, Language):**

**You are referring the patient for what surgery:**

**Rational for referral to surgery at this time:**

**Goals for surgery:**

**How will surgery improve your clients functioning?** How will it make their life better?

**Transition Related Surgery Planning Visits regarding this surgery:**

**Gender History:**

**Any steps in social transition and when:**

**Length of time on hormones and response:**

**Gender Dysphoria diagnosis made:**

**Informed consent.** If limitations are present or there are issues regarding communication (English fluency, literacy level, learning differences etc) please describe:

**Medical conditions (stable and well controlled).** Comment if surgery may be potential for destabilization:

**Current and past substance use, including nicotine.** List any concerns you or the client has regarding their substance use or their sobriety and any implication of using pain medication:

**BMI:**

**Mental health history (stable and well controlled).** Comment if surgery may be potential for destabilization:

**Fitness for surgery:**

**Medications:** List is included

**What is the patients after care plan (where, supports):**

**Support system:**

**A discussion about surgery was had including risks and benefits:**

Potential alterations in feeling and sexual function (depending on surgery)

Risks and benefits of surgery and alternatives to surgery

The impact of smoking, drugs and alcohol on surgery and surgical outcomes

The experience and impact of pain physically and/or emotionally

The importance of after care related to post-operative complications and aesthetic outcomes

Limits to fertility and reproductive choices

**Realistic expectations (if not – what is being done to address this):**

* Aesthetic outcome of surgery and impact on dysphoria
* Functional outcome following surgery
* Potential for complications
* Level of support needed during recovery
* Erotic sensation and sexual function

Thank you for accepting this referral for patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_for \_\_\_\_\_\_\_\_\_\_\_\_ surgery. Please feel free to contact me if you require further information at: \_\_\_\_\_\_\_\_. I look forward to working with you to coordinate care for this patient.

Inclusions

WCH Cover page

Referral letter 1

Referral letter 2

Ontario MOH Approval