BCCH GENDER CLINIC
Gender Clinic: 604-875-2345 x6550
Toll-free Phone: 1-888-300-3088 x6550
Fax: 604-875-3231
http://endodiab.bcchildrens.ca
bcchgenderclinic@cw.bc.ca

BCCH GENDER CLINIC REFERRAL FORM

We look forward to supporting your patient. Here are some important points to know:

- We only accept referrals for patients **before their 17th birthday**. If you would like to discuss a specific case, please call our team.
- Most patients will initially be offered an **intake appointment with a nurse and/or social worker**. This appointment is focused on supporting the youth and family, providing guidance on possible next steps and sharing resources.
- Some youth may be ready for a medical appointment to discuss starting puberty blockers or hormones. We will determine this once we have reviewed the referral.
- We are not a mental health clinic. We cannot respond to mental health crises.

REQUIRED INFORMATION IS MARKED WITH A * — IF LEFT BLANK, THE REFERRAL MAY BE RETURNED.

Date of referral: _____ (YYYY/MM/DD)

Referring MD/NP: _____ MSP#: _____

MD/NP phone: _____ MD/NP fax: _____

*Who should we contact to arrange appointments? ☐ guardian ☐ youth ☐ other: _____

CHILD'S/YOUTH'S INFORMATION:

*Legal first name: _____ *Legal last name: _____

Chosen name: _____ *Date of birth: _____ (YYYY/MM/DD)

Gender identity: ☐ male ☐ female ☐ non-binary ☐ other: _____

Pronouns used: ☐ he/him ☐ she/her ☐ they/them ☐ other: _____

*PHN: _____ *Sex assigned at birth: ☐ male ☐ female

Youth's cell phone†: _____ Youth's email†: _____

†note: if email is provided, this means that you have obtained consent for us to contact the youth by email

*Youth's home address: _____

Puberty status: The following information helps us triage — any information provided is helpful.

Natal female puberty:

breast growth: ☐ yes ☐ no

menstruating: ☐ yes ☐ no. If "yes", for approximately how long? _____

Natal male puberty:
testicular/penile growth: ☐ yes ☐ no
voice change: ☐ yes ☐ no

If your patient is seeking medical treatment (puberty blockers/hormones), a readiness assessment must be completed by a trans-competent mental health assessor prior to starting treatment. Patients without assessments will still be seen for an intake appointment, and we can help direct them to an assessor, if needed.

Is your patient seeing or waitlisted to see a mental health assessor? ☐ yes ☐ no ☐ unsure

If "yes", please provide assessor's name and contact information (if available):

_____

If "no", would you like our assistance in helping your patient find an assessor prior to their intake appointment? ☐ yes ☐ no

FAMILY INFORMATION:

*Are parents/guardians aware of this referral?[¶] ☐ yes ☐ no

[¶]note: youth do not always want their parents/guardians to be informed of their visits to our clinic

Parent(s)/guardian's name(s): _____

*Parent/guardian phone[‡]: _____ OK to leave a message? ☐ yes ☐ no

Parent/guardian email[‡]:_____

[‡]note: if email is provided, this means that you have obtained consent for us to contact the family by email

Is this child/youth in Ministry (MCFD) care? ☐ yes ☐ no.

If "yes", name of worker: _____

Interpreter required? ☐ yes ☐ no. If "yes", for which language: _____

IMPORTANT: Please be sure to include all pertinent reports with your referral. We will contact the family directly with the appointment time.

Reason for referral: