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 accept referrals for patients under 17 years of age, unless a physician calls us to discuss special circumstances. Please note that we are not a mental health clinic and cannot respond to urgent mental health concerns.

We look forward to supporting your patient in their journey. This referral will prompt a member of our Gender Clinic to reach out to your patient and offer an intake appointment. The intake appointment is not a medical appointment, but it will allow our team to better understand your patient's situation, share resources, and provide support.

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 seeing a pediatric endocrinologist.

Is your patient currently seeing / waitlisted to see a **trans-competent mental health assessor?**

☐ Yes ☐ No

If Yes, please provide assessor's name and contact information:

Assessor's name: _____

We can discuss options for mental health assessments with your patient at the time of their intake appointment, or you may want to share this information with your patient in advance. Would you like us to fax you a list of recommended mental health assessors?

☐ Yes ☐ No

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

Referring MD/NP: _____ MSP#: _____

Phone: _____ Fax: _____

Child/Youth's Information

Legal first name: _____ Legal last name: _____

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

PHN: _____ Sex assigned at birth: ☐ M ☐ F

Gender expression: _____ Pronouns: _____

Tanner stage if known: _____

Date of first menstrual cycle (if applicable): _____

Family Information

Who should we contact to arrange appointments? _____

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

Patient address: _____

Is this child/youth in Ministry care? ☐ Yes ☐ No

If "Yes", social worker and contact info: _____

Home phone: _____ Youth's cell phone: _____

Parent/guardian cell phone: _____ Parent/guardian cell phone: _____

Email: _____

Interpreter/language? _____

IMPORTANT: Please be sure to include all pertinent reports with your referral. The referral will be prioritized by the gender team and the patient will be contacted directly with the appointment time.

Reason for referral:

Missing information will delay our ability to schedule an appointment for this patient.