BCCH GENDER CLINIC
Gender Clinic: 604-875-2345 x6550
Toll-free Phone: 1-888-300-3088 x6550
Fax: 604-875-2426
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.
- **Please share with families** that 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. A social worker or nurse may reach out directly to families prior to intake if more information is needed.
- 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.

*To your knowledge, are parents/guardians aware of this referral?[¶] ☐ yes ☐ no ☐ unsure
*To your knowledge, are parents/guardians supportive of this referral?[¶] ☐ yes ☐ no ☐ unsure
[¶]note: youth do not always want their parents/guardians to be informed of their visits to our clinic

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: ☐ man/boy ☐ woman/girl ☐ 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 cell or email is provided, this means that you have obtained consent for us to contact the youth this way

*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. Wayfinding to a readiness assessor and other resources can be discussed in the intake appointment.

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

FAMILY INFORMATION:

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: