



Gender-Affirming Care Referral

Fax: 250-361-3422

Patient information:

Affirming or chosen name:

Pronouns:

Legal name (as appears on BC Services Card):

PHN:

Province/territory:

Date of birth (YYYY-MM-DD):

Email:

Phone:

☐ Consent obtained to reach out to patient by phone and email

Referring healthcare provider:

Name:

MSP#:

Phone:

Fax:

Medical history and current medications (please attach letter if more space is needed):

Has the patient accessed gender affirming care previously? If so, please describe:

Reason for gender-affirming care referral (check all that apply):

- ☐ Hormone readiness assessment (HRA)
- ☐ Hormone therapy initiation and stabilization (includes informed consent HRA process, as needed)
- ☐ Surgical readiness assessment (SRA)
- ☐ Surgical referral (includes SRA, if needed)
- ☐ Other (please describe):

For all referrals to Island Sexual Health for gender affirming care, we offer initial assessment, stabilization and support, followed by a transfer of care back to the primary care provider.

- ☐ I (the referring provider) agree to receive a transfer of care back for ongoing maintenance treatment, as necessary, with the guidance provided by Island Sexual Health; OR
- ☐ I (the referring provider) refuse to receive transfer of care, and the reason for this is:

_____ (response required)