**Referral to the Gender Identity Clinic**

**All sections of the form are compulsory and must be completed to ensure the referral is accepted.**

**Breast augmentation, thyroid chondroplasty (tracheal shave) or cricothyroid approximation (vocal pitch) surgery are not currently funded by NHS England Specialist Commissioning.**

|  |  |  |
| --- | --- | --- |
| **Date of Referral** | **\_ \_ / \_ \_ / 20 \_ \_** |  |

|  |
| --- |
| **Patient Details** |
| **Full Legal Name** |  | **D.O.B** | \_ \_ / \_ \_ / \_ \_ \_ \_ |
| **Preferred name (if different)** |  | **Sex assigned at Birth** *please circle***:** | **Female** | **Male** |
| **Address** |  | **NHS Number** |  |
| **Patient Telephone** |  | **Patient Mobile** |  |
| **Int*e*rpreter Required** | [ ]  **Yes** | [ ]  **No** | **If required, what language** |  |
| **Can patient attend clinic independently** | [ ]  **Yes** | [ ]  **No** | **If no, please give more information** |  |
| **Patient born of a multiple pregnancy (e.g. twins)?** | [ ]  **Yes** | [ ]  **No** | **Has patient been seen at this GIC previously?**  | [ ]  **Yes** | [ ]  **No** |
| **GP Details** |
| **GP Name** |  | **GP Practice Name** |  |
| **GP Address** |  | **GP Telephone** |  |
| **GP Fax** |  | **GP E-mail** |  |
| **Referrers Details** *only if the referrer is* ***not*** *the patient’s GP* |
| **Referrer Name** |  | **Referrer Job Title** |  |
| **Referrer Address** |  | **Referrer Telephone** |  |
| **Referrer Fax** |  | **Referrer E-mail** |  |
| **The Referrer** (*if the referrer is not the GP)* **may need to liaise with the patient’s GP to obtain this information** |
| **Detailed reason for referral** |
|  |
| **Social role change** |
|  | **Yes** | **No** | **N/A** | **Comments** |
| **Has the patient made a social role transition to their preferred gender role?** |  |  |  |  |
| **Have they made an official name change?** |  |  |  |  |
| **Have they registered their new legal name at their GP surgery?** |  |  |  |  |
| **Medical history (including computerised printout)** |
|  |
| **Current medications (prescribed and non-prescribed) including hormones, contraceptives and herbal medicines** |
| **Name** | **Dose** | **Prescribed by/ obtained from** | **Duration** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Up-to-date mental state examination**  |
|  |
| **Mental health background (any diagnosed or suspected mental health problems or mood disorders) including previous risk, substance misuse, and secondary care mental health input.** |
|  |
| **Forensic history**  |
|  |
| **Any other agencies involved** |
|  |
| **Any other relevant information or comments** |
|  |

**Physical Health Assessment-**

**The Referrer** (*if the referrer is not the GP)* **may need to liaise with the patient’s GP to obtain this information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Physical Health Assessment****at GP** |  |  |  |
| **Height** (metres): |  | **Weight** (kg): |  |
| **Waist** (cm) **:** |  | **BMI:** |  |
| **Blood Pressure:** |  | **Heart Rate:** |  |
| **Polycystic ovarian syndrome** | [ ]  **Yes** | [ ]  **NO** | [ ]  **N/A** | **Physical intersex condition** | [ ]  **Yes** | [ ]  **NO** |

|  |  |
| --- | --- |
|  | **Amount/details** |
| **Does the patient smoke?** | [ ]  **Yes** | [ ]  **NO** |  |
| **Does the patient drink alcohol?** | [ ]  **Yes** | [ ]  **NO** |  |
| **Does the patient use recreational drugs?** | [ ]  **Yes** | [ ]  **NO** |  |

**Please note: We ask patients to stop smoking completely at least 3 months prior to starting hormones because the thromboembolic (clotting) risk with oestrogens and polycythaemia risk with androgens is raised to unacceptable levels in people who smoke. Also, surgical outcome is better in non-smokers. Any form of nicotine replacement, including electronic cigarettes, is considered safe. Advice and support is available through GPs and NHS smoking cessation services.**

**Blood tests**

**In order to make a full assessment, we require all patients to have blood tests and bring the results to their first appointment.**

**Patients will receive the list of required blood tests in their appointment letter (approximately 4-6 weeks before the appointment).**

**Please complete the blood tests and provide the patient with a computerised printout for them to bring to their first appointment.**

* **Please note the requirements regarding GPs’ commitment to hormone treatment when making the referral.**
* **The Gender Identity Clinic will recommend and advise on hormone treatment and monitoring as appropriate**

|  |  |  |
| --- | --- | --- |
| **Referrer’s Signature:** | **Referrer’s Job Title** | **Date:** |
|   |  |  |

Please return this form to: **Referral and Funding Team**

Gender Identity Clinic

 179-183 Fulham Palace Road

 London

 W6 8QZ

 Tel: 0208 938 7590

 Fax: 0208 181 4506

 Email: gic.administration@nhs.net

 Website: [gic.nhs.uk](https://gic.nhs.uk/)