

HEALTH STATUS

INFORMATION FORM

This form must be completed by the primary physician and the patient.
Please send us the completed form as soon as possible.

PATIENT IDENTIFICATION			
Legal Name:	Legal first name:		
Chosen last name:	Chosen first name:		
Date of birth (yyyy-mm-dd):	Health number:		
Weight: kg	Height: cm	BMI*:	
Surgical Procedure:			
PHYSICIAN'S INFORMATION	YES	NO	PRECISIONS
1. I am the primary care provider (GP, NP) who regularly monitors this person's overall health.	☐	☐	Date of the last consult: _____
RESPIRATORY	YES	NO	
1. Does this person have any respiratory problems such as asthma, bronchitis COPD or emphysema?	☐	☐	
2. Does this person suffer from sleep apnea?	☐	☐	Does this person use her sleep apnea device?
NEUROLOGY	YES	NO	
1. Has this person ever had a stroke?	☐	☐	Description of aftereffect:
2. Does this person have any neurological problems such as Parkinson's disease, multiple sclerosis, cerebral palsy, etc.?	☐	☐	
ANESTHESIA	YES	NO	
1. Has this person ever had problems with anesthesia or had a reaction to it?	☐	☐	If so, please specify:
2. Does this person or a family member suffer from malignant hyperthermia?	☐	☐	If so, please specify relation to this person:
CARDIAC AND VASCULAR	YES	NO	
1. Does this person have any heart problems such as congenital malformations, heart murmur, angina, heart attack, palpitations, heart failure, etc.?	☐	☐	If so, does this person have a pacemaker, a defibrillator or a heart valve?

Name, Surname: _____

Date of birth: _____

HEMATOLOGY	YES	NO	PRECISIONS
1. Does this person suffer from any blood coagulation anomalies, hematological disorders or anemia?	☐	☐	If so, please specify:
2. Has this person ever had phlebitis or a pulmonary embolism?	☐	☐	
3. Does this person suffer from liver problems?	☐	☐	
RENAL	YES	NO	
1. Does this person have any kidney problems (chronic kidney disease, transplant, undergoes dialysis)?	☐	☐	If so, please provide the results of the patient's last renal checkup:
ENDOCRINOLOGY	YES	NO	
1. Is this person diabetic?	☐	☐	If so, please specify: ☐ Type 1 ☐ Type 2 Please provide glycated hemoglobin assay. *To do if not available
MENTAL HEALTH - SUBSTANCE ADDICTION	YES	NO	
1. Does this person suffer from any mental health problems (depression, anxiety, bipolarity, schizophrenia, personality disorder, etc.)?	☐	☐	If so, please specify: Are the mental health issues resolved, controlled, or uncontrolled?
2. Does this person have addiction issues with medications, drugs, or alcohol?	☐	☐	If so, please specify the substance:
3. Has this person been hospitalized for mental health problems in the past year?	☐	☐	
OTHER	YES	NO	
1. Is there any other information you would like to share about this person's health?	☐	☐	

☐ I have reviewed this questionnaire with the patient, and I acknowledge that the information it contains is complete and accurate.

Name of the primary care provider who completed this form

Signature

Date

Last name, first name: _____ Date of birth: _____
(yyyy-mm-dd)

Sex assigned at birth: _____ Age: _____

Questionnaire to assess sleep apnea

Risk factors	Questions and Benchmarks	Identified Risks	
Snoring	Do you snore loudly (loudly enough to be heard through closed doors or that your bed partner elbows you during the night for snoring)?	Yes ☐	No ☐
Fatigue	Do you often feel tired, fatigued, or sleepy during the day?	Yes ☐	No ☐
Respiratory stop	Has anyone noticed that you stop breathing or are choking/gasping for air during your sleep?	Yes ☐	No ☐
Blood pressure	Do you have or are you being treated for high blood pressure?	Yes ☐	No ☐
BMI	Is your Body Mass Index higher than 35 kg/m2?	Yes ☐	No ☐
Age	Are you over 50 years of age?	Yes ☐	No ☐
Large neck size (measured around the Adam's apple)	If you were assigned male at birth , is your shirt collar 43 cm/17 inches or larger? If you were assigned female at birth, is your shirt collar 41 cm/16 inches or larger?	Yes ☐	No ☐
Sex	Were you assigned male at birth?	Yes ☐	No ☐
Score		.	.

Last name, First name: _____

Date of birth: _____

Score criteria:**Low risk** of OSA: Yes to 0 to 2 questions**Intermediate risk** of OSA: Yes to 3 to 4 questions**High risk** of OSA: Yes to 5 to 8 questions

or Yes to 2 or more of the first 4 questions + assigned male at birth

or Yes to 2 or more of the first 4 questions + BMI > 35 kg/m²

or Yes to 2 or more of the first 4 questions + neck circumference

(43 cm/17 inches for assigned male at birth, 41 cm/16 inches for assigned female at birth)¹**Risk assessment**

Low risk



Intermediate risk



High risk

Risk	Instructions
Low risk	We consider it safe for the patient to undergo surgery.
Intermediate risk	Please make further assessment of sleep apnea through polysomnography at home or in a sleep laboratory. The results must be sent to our team of anesthesiologists who will assess the possibility to perform surgery or not at the Centre Métropolitain de Chirurgie.
High risk	

Note that regardless of the level of risk, the patient aged 40 years and older with at least a comorbidity will be evaluated by our team of anesthesiologists to ensure a safe surgery.

Signature of primary care provider_____
Date

¹ Tool adapted by the Centre Métropolitain de Chirurgie (2020) from STOP – Bang Method®, University Health Network

CONSENT TO ACCESS AND DISCLOSE INFORMATION RELATING TO MY HEALTH

TO BE COMPLETED **BY THE PATIENT** and returned to us as soon as possible

In the context of your request for gender affirmation surgery at GrS Montréal, Complexe chirurgical CMC, its affiliates, successors and assigns, the physicians practicing therein and their agents and delegates who require such information in the performance of their duties (collectively, "CC-CMC") may need to communicate or request certain personal information for the processing and follow-up of your file.

The personal information collected is as follows:

- Your personal identifiers,
- Your medico-psycho-social information,
- Surgery information,
- Emergency contact information,
- Contact information for the professionals involved,
- Travel details,
- Photos and videos identifying you (face and distinctive physical features).

METHODS OF DATA COMMUNICATION

Data will be communicated using virtual care tools (e-mail, telehealth, telephone and Monarch platform if applicable), as well as by fax and mail.

I, the undersigned, grant and authorize:

1. The professional(s) identified below to disclose and transmit to the CC-CMC, any information relating to my state of health, including but not limited to, any notes, results or medical information necessary to provide me with healthcare, including preparation steps and follow-up relating to the surgery I will undergo or for the purpose of developing a treatment plan.
2. Also, the CC-CMC to communicate and exchange information with such professional(s) concerning my state of health when necessary to provide me with healthcare, including but not limited to the preparation steps and follow-ups related to my surgery, or for the purpose of developing a treatment plan.

Name of family doctor or nurse practitioner (NP) or one of their designated representative or delegates:

Name of mental health professional or psychosocial professional if applicable:

Other professional(s) if applicable (please specify):

For patients under the age of 18 or under guardianship (optional):

I also authorize my parent identified below to receive information from CC-CMC about my state of health.

Surname and first name of my parent or guardian: _____

Date of birth of my parent or guardian: _____ (yyyy-mm-dd)

ACCESS, RECTIFICATION AND CANCELLATION RIGHTS

If you have any questions or comments about this Consent or your personal information, submit a request for access or rectification, or file a complaint, please contact the person responsible for personal information at the following address:

Complexe chirurgical CMC
999 De Salaberry Street
Montréal, Québec H3L 1L2

or via email: confidentialite@complexechirurgicalcmc.com

WITHDRAWAL

I understand that I may revoke this consent in whole or in part, except to the extent that CC-CMC has already communicated or received information based on this consent.

CONSENT

By signing this document,

- I acknowledge that I have read the above explanations and that I have had the opportunity to ask the questions necessary for my understanding and have received the answers.

SIGNATURE OF PATIENT

Full name:

Date of birth: (yyyy-mm-dd)

Date: (yyyy-mm-dd)

Signature: _____

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