

Last name:
First name:
Date of birth:

RECOMMENDATION FORM

TO BE FILLED OUT BY THE REFERRING PROFESSIONAL

PATIENT IDENTIFICATION

Legal last and first names:

Chosen last and first names (if different):

Pronouns:

Date of birth:

GrS Montréal follows WPATH standards of care Version 8. Therefore, it is not mandatory to be a mental health professional to conduct an assessment in order to provide a recommendation for surgery. However, a master's level of education is required as well as knowledge of medical and surgical treatments in trans health. Our team will communicate with you if we have questions about the type of follow-up you offer or about the information contained in the letter of recommendation.

REFERRING PROFESSIONAL

Last and first names: _____

Title: _____

Email address:

Telephone:

Fax:

If this is your first referral to our center, please complete **the following section.**

New referring physician

Completed level of study:

Practice location:

Available services: _____

Trans health expertise:

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Please attach the [consent form to disclose personal information](#) with this form.
Feel free to add a sheet if you require more space.

- Document gender dysphoria or incongruence (duration, impact on functioning, etc.):

- Transition steps taken so far:

- Have these steps contributed to a reduction in gender dysphoria or incongruence? Yes No
If not, why?

- Has the patient received a mental health diagnosis? If yes, please specify. Yes No

- Is the patient on hormone therapy? Yes (please specify) No (please specify why)
Since:
Since:
Since:

- In the case of gonadectomy, what type of hormones does the patient wish to take after the surgery?

- Have sterilization and fertility preservation options been discussed? Yes No

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- What are their expectations and goals related to the desired surgery/surgeries?

- Do they have knowledge of postoperative care associated with the surgery? Yes No

If yes, summarize the main points expressed by the patient. **If not**, summarize the actions taken.

- Describe the patient's family and social support network:

- Healthcare professionals involved in the patient's care (specialties) :

Will you be available for follow-up after surgery if the patient requires it? Yes No

For questions 1 to 8, if you answer NO, please fill in the corresponding number in Appendix 1

- | | | |
|---|------------------------------|------------------------------------|
| 1. Is the patient capable of giving informed consent? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. They understand that the results may differ from their wishes: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Ability to adapt if results differ from expectations? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Ability to take care of themselves (hygiene, diet, etc.): | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Has good lifestyle habits: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. They live in a clean, stable and safe home: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Financial capacity to stop working during convalescence: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Financial capacity to purchase the necessary supplies: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

For questions 9 to 15, if you answer YES, fill in the corresponding number in Appendix 1.

- | | | |
|--|-------------------------------------|-----------------------------|
| 9. Neurodevelopmental disorders: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Risk of mental health deteriorating in times of stress: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Substance use (current): | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Substance use (past): | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Known physical health conditions: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Patient under 18: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Communication difficulties (language, physical restrictions, etc.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

SIGNATURE OF THE REFERRING PROFESSIONAL

Signature :

Date :

APPENDIX 1

1. Why is the patient not capable of giving informed consent?
2. What are the issues regarding expectations of surgical results?
3. What are the issues regarding adaptation to surgical results?
4. **Ability to take care of themselves.** What are the identified issues related to this matter?
5. **Lifestyle habits.** What are the identified issues related to this matter?
6. What are the identified issues related to their home situation?

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7. and **8.** What resources will be deployed to ensure the patient is financially able to meet their postoperative needs and obtain the necessary supplies?

9. Neurodevelopmental disorders. What are the manifestations, and what are your recommendations for patient interaction, communication and care?

10. Risk of mental health deteriorating in times of stress. What are the manifestations, if any, and what strategies have been developed?

11. and **12.** Substance use (current and past):

Types of substance:

Since when or for how long (approximate dates):

Treatments:

Are these treatments still ongoing? Yes No

13. What are the known health conditions? Please specify whether these problems are treated and stable. *If you are their family doctor or nurse, please complete the [health questionnaire](#) instead ().*

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14. Patients under 18. Describe the social and professional support network available before, during and after surgery.

15. Communication difficulties. Describe the patient's limitations and the available resources to ensure good understanding before, during and after surgery.

SIGNATURE OF THE REFERRING PROFESSIONAL

Signature :

Date :

Please feel free to contact us should you have any questions.

ADDITIONAL INFORMATION

Signature: _____

Date: _____