GrS MONTRÉAL

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: _____

REFERRING PROFESSIONAL

If this is your first referral to our center, please complete Appendix 2 on page 5.

Last and first names: _____

Title: _____

Email address: _____

Telephone: _____ Fax: _____

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: _____

If not, why? _____

Complexe chirurgical CMC
514 288-2097
document@grsmontreal.com

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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

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 <u>NO</u>, please fill in the corresponding number in Appendix 1

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

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

9. Neurodevelopmental disorders:	☐ **Yes**	☐ No
10. Risk of mental health deteriorating in times of stress:	☐ **Yes**	☐ No
11. Substance use (current):	☐ **Yes**	☐ No
12. Substance use (past):	☐ **Yes**	☐ No
13. Known physical health conditions:	☐ **Yes**	☐ No
14. Patient under 18:	☐ **Yes**	☐ No
15. Communication difficulties (language, physical restrictions, etc.)	☐ **Yes**	☐ No

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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 (https://www.grsmontreal.com/DATA/DOCUMENT/94.pdf).*

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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.

_____

_____

_____

APPENDIX 2

New referring physician

Completed level of study: _____

Practice location : _____

Available services : _____

_____

_____

Trans health expertise: _____

_____

_____

REFERRING PHYSICIAN'S SIGNATURE

Signature: _____ Date: _____

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

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ADDITIONAL INFORMATION

Signature: _____ Date: _____