GrS MONTRÉAL | COMPLEXE CHIRURGICAL

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: _____
Phone number: _____ Email address: _____
Requested surgery(ies): _____

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:

Complexe chirurgical CMC
document@grsmontreal.com
Phone: 514 288-2097 / Fax: 514 288 3547

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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: _____

If not, why?

- 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 <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 |

**SIGNATURE OF THE REFERRING PROFESSIONAL**

Signature : _____ Date : _____

Last name:
First name:
Date of birth:

**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?

**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 ().*

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: