Date:

Referral form to the Gender Wellbeing Clinic

☐ **ADULT – over 16 years of age**

☐ **PAEDIATRIC- under 16 years of age**

Personal Details	
ID No/Passport No	
Name & Surname	
Address	
Contact Number	
Age	
Sex at birth ***(Circle selection)***	Male Female Indeterminate Unknown
Gender	Legal Gender: Preferred gender:

Reason for Referral	
Has already started a gender transition ***(Circle selection)***	Yes / No If yes: Medical practitioner managing condition:_____ Medical therapy: Date started and type: _____ _____

Referral ticket: GWC_Version 2.0
Expires in Jan 2021

	Surgery related to gender: _____ _____ _____ _____
Further Comments	
Has a social transition to desired gender role already taken place? ***(Circle selection)***	Yes/No Duration_____
Past Medical History	
Past Surgical History	
Social History ***(Circle selection)***	Smoking Y/N No.of cigs._____ Alcohol Y/N Units per week: _____ Other _____
Family Support ***(Circle selection)***	Y/N Comments_____ _____
Drug History **Drug Allergies**	
Further notes	
Scanned notes (to be sent together with referral ticket)	No of sheets:

Referral ticket: GWC_Version 2.0
Expires in Jan 2021

Name & Surname of person making referral	***If the person making the referral is not a medical doctor please advise client to bring relevant medical documentation/ a copy of recent prescriptions to the healthcare appointments***
Profession	
Council Registration No	
Contact No	
Electronic Signature (if available)	
For administrative use	
Date Received	
Date of appointment given	Y/N Date:
Category	New case Fast-track

NOTE: IF REFERRING PERSON IS NOT IDENTIFIABLE OR CONTACTABLE – THIS FORM WILL NOT BE PROCESSED