CHEO GENDER CLINIC REFERRAL FORM

We look forward to collaboratively supporting your patient. Here are some important points to know:

- We only accept referrals for patients who are *Pubertal and <16.5* years old in Ontario and Nunavut. If you would like to discuss a specific case, please call our team at 613-737-7600 ext. 3912.
- Patients will initially be offered an intake appointment with a Social Worker. This appointment is focused on supporting the youth and family, providing guidance on possible next steps, and sharing resources.
- We are not a mental health clinic. We cannot respond to mental health crises.

REQUIRED INFORMATION IS MARKED WITH A * — IF LEFT BLANK, THE REFERRAL MAY BE RETURNED.

Date of referral: _____ (YYYY/MM/DD)

Referring MD/NP: _____

MD/NP phone: _____Fax: _____

*Who should we contact for appointments? Guardian☐ Youth ☐ other:

CHILD'S/YOUTH'S INFORMATION:

*Legal first name: _____*Legal last name: _____

Chosen (Preferred) name: _____ *Date of birth: _____

Gender identity: male☐ female☐ non-binary☐ Questioning☐ other_____

Pronouns: _____Can we use preferred name and pronouns in front of parents? _____

*Sex assigned at birth: male ☐ female ☐

*OHIP: _____

Youth's cell phone†: _____ Youth's email†: _____

*Youth's home address: _____

Is Youth living away from home? (Provide details/address) _____

Puberty status: This information helps us triage — any information provided is helpful.

Assigned female at birth: breast growth: Yes☐ No☐

Menstruating? _____ If "yes", for approximately how long? _____

Assigned male at birth: testicular/penile growth: Yes☐ No☐ Voice change: Yes☐ No☐

Tanner Stage: _____

FAMILY INFORMATION:

*Are parents/guardians aware of referral? Yes☐ No☐ Are Parents Supportive? Yes☐ No☐

¶note: youth do not always want their parents/guardians to be informed of their visits to our clinic

Parent(s)/guardian's name(s): _____

*Parent/guardian phone: _____ OK to leave a message? Yes☐ No☐

Parent/guardian email: _____

Is this child/youth involved with CAS? Yes☐ No☐

If "yes", Name of worker: _____Phone: _____

Interpreter required? _____ If "yes", for which language: _____

Reason for referral: *Please provide as much detail as possible- Inc.* ***Transition Goals***

Please complete and FAX to CHEO Adolescent Health Clinic C5 – **Fax: 613-738-4258.**

IMPORTANT: Please be sure to include all pertinent reports with your referral. We will contact the youth's preferred phone number directly with the appointment time.

*****INCOMPLETE REFERRALS WILL BE RETURNED*****