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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 E }

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*****