**GP/HEALTHCARE PROFESSIONAL Referral to the Gender Identity Clinic**

**Please note:** We do not accept private referrals.

If the patient is under 17 years old, Arden and Greater East Midlands Commissioning Support Unit (Arden & GEM CSU) on behalf of NHS England. Arden & GEM CSU can be contacted at agem.CYP-GD@nhs.net

**If the patient is currently receiving treatment from another NHS GIC service please contact the service to request a transfer to us**.

If you are a GP or another health professional and you would like to refer a patient to the Gender Identity Clinic, please complete the referral form and refer using eRS.

**Please do not send blood work with the referral form.**

**Breast augmentation, thyroid chondroplasty (tracheal shave) or cricothyroid approximation (vocal pitch) surgery are not currently funded by NHS England Specialist Commissioning.**

***Fields marked with an asterisk \* are required to be completed. Incomplete referral forms will be rejected.***

|  |  |  |
| --- | --- | --- |
| **Date of referral \*** |  |  |

|  |
| --- |
| **Patient Details** |
| **Full legal name \*** |  | **Sex assigned at birth \*** |  |
| **Preferred name (if different)**  |  | **Date Of Birth \*** |  |
| **Address \*** |  | **NHS Number \*** |  |
| **Patient email (only the patient’s email address) \*** |  | **Patient mobile number (or reason for not disclosing) \*** |  |
| **Interpreter Required? If so which language? \***  |  |  |  |
| **Does the patient have any other communication support needs? \***  |  | **If yes, please give more information** |  |
| **Patient agreed forms of communication** (please tick)\* | [ ]  Email [ ]  Text (SMS)[ ]  Post [ ]  Phone | **Patient Ethnic origin\***  |  |
| **Can the patient attend the clinic independently \***  |  | **If no, please give more information**  |  |
| **Has patient been seen at this GIC previously? \***  | [ ]  **Yes** | [ ]  **No** |

 **Primary reason for referral (Please tick one)**

|  |  |  |
| --- | --- | --- |
| **Assessment & Treatment (complete Section 1)** | [ ]  **Yes** | [ ]  **No**  |
| **Advice**  | **Endocrine (complete Section 2)** | [ ]  **Yes** | [ ]  **No** |
| **Other (please specify in Section 3 )**  | [ ]  **Yes** | [ ]  **No** |

|  |
| --- |
| **GP Details** |
| **GP Name, Practice and Address** \* |  | **GP Telephone** \* |  |
| **GP E-mail** \* |  |

|  |
| --- |
| **Referrers Details** *only if the referrer is* ***not*** *the patient’s GP* |
| **Referrer Name and job title** \* |  |  **Referrer Address\*** |  |
| \* **Referrer E-mail** \* |  | **Referrer Telephone** \* |  |

|  |
| --- |
|  **Detailed reason for referral \*** |
|  |

|  |
| --- |
| **Medical history \***  |
|  |

**SECTION 1**

|  |
| --- |
| **Current medications (prescribed and non-prescribed) including hormones, contraceptives and herbal medicines** |
| **Name** | **Dose** | **Prescribed by/ obtained from** | **Duration** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Physical Health Assessment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Height**(metres) |  | **Weight (kg)**  |  | **BMI** |  | **Blood pressure:** |  |
| **Does the patient smoke** | [ ]  **Yes** | [ ]  **No**  | **Amount per week:** |
| **Alcohol consumption?** | [ ]  **Yes** | [ ]  **No**  | **Amount per week:** |
| **Recreational drug use?** | [ ]  **Yes** | [ ]  **No** | **Amount per week:** |

**MENTAL HEALTH**

|  |
| --- |
| **Mental health background including current and historical risk and any substance misuse**  |
|  |

**FORENSIC HISTORY**

|  |
| --- |
| **Forensic history (including index offense, previous and current convictions, length of sentence, length of license, probation details, mental health section, responsible clinician contact details etc.)**  |
|  |

**Please include the following:**

[ ]  **Printout of the GP medical summary, including current medications**

[ ]  **Relevant reports and assessments for physical/mental health/forensic**

 **(e.g. ASD assessment report, mental health diagnostic report, etc.)**

[ ]  **Reports from other gender healthcare providers if applicable**

[ ]  **Risk assessments and management plans if applicable**

**SECTION 2**

**ADVICE**

|  |
| --- |
| **Please state advice required**  |
|  |
| **Any other relevant information or comments**  |
|  |

**SECTION 3**

**OTHER**

|  |
| --- |
| **Do you have any access requirements you would like to make us aware of? Please specify below**  |
|  |
| **Any other relevant information or comments**  |
|  |