**SELF-REFERRAL to the Adult Gender Identity Clinic**

**Please note:** We do not accept under 17 years 9 months and private referrals.

If you are under 17 years 9 months old, please ask your GP to contact Arden and Greater East Midlands Commissioning Support Unit (Arden & GEM CSU) agem.CYP-GD@nhs.net

To assist us with processing your referral form, when submitting your form please email in a **PDF version** to gic.referrals@tavi-port.nhs.uk. Thank you in advance.

**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 \*** |  |  |

|  |
| --- |
| **Your 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** |  |
| **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 at least one)**

|  |  |  |
| --- | --- | --- |
| **Assessment & Treatment (complete Section 1 and 2)**  | [ ]  **Yes** | [ ]  **No**  |
| **Advice (complete Section 3 if Yes)** | [ ]  **Yes** | [ ]  **No**  |

**SECTION 1**

Please forward Section 1 and 2 of this referral form must be completed by your GP. Without this information the Self-Referral would be deemed in complete and unable to proceed with the referral.

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

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| **Referrers Details** *only if the referrer is* ***not*** *the patient’s GP* |
| **Referrer Name and job title** \* |  |  **Referrer Address**\* |  |
| \* **Referrer E-mail** \* |  | **Referrer Telephone** \* |  |
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|  **SECTION 2**  Please forward Section 1 and 2 of this referral form must be completed by your GP. Without this information the Self-Referral would be deemed in complete and unable to proceed with the referral. |

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| --- | --- |
| **Name of Patient \*** |  |
| **Date of Birth \*** |  |
| **NHS Number \*** |  |

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|  **Detailed reason for referral \*** |
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| **Medical history \***  |
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| **Current medications (prescribed and non-prescribed) including hormones, contraceptives and herbal medicines** |
| **Name** | **Dose** | **Prescribed by/ obtained from** | **Duration** |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |

**Please include printout of GP medical summary, including current medications**

**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**

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

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| --- |
| **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 3**

**ADVICE**

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