Trans Health Referral

Date: / / REFERRAL FORM

FAX TO: 519-660-8638
INTAKE PHONE: 519-660-0875
CLIENT MUST RESIDE IN LONDON MIDDLESEX

PROVIDER / PHYSICIAN INFORMATION (IF AVAILABLE)			
Physician Name		Referral Date	
Phone Number or Email Address		Address	
Notes / Reason for Referral:			

CLIENT INFORMATION			
Legal Name		Preferred Name	
Date of Birth		Spoken Language	☐ English ☐ French ☐ Other: ☐ Requires Interpreter
Phone Number	Consent to leave message ☐	Address with Postal Code	
Gender		Pronouns	
Email Address			
Client provided verbal consent to participate in Trans Care at LIHC:		☐ Yes	☐ No

SERVICES REQUESTED (Check All That Apply)	
☐ Mental Health / Social Support ☐ Medical Care ☐ Identification Support ☐ Anonymous HIV testing ☐ Hepatitis C Care ☐ Youth Outreach Workers ☐ Other – Please specify in notes	NOTES:

Please note that once we receive this document, we will be in touch with you to discuss service and program options.

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London ON N5W 2Z1
Tel: 519-660-0874
Fax: 519-642-1532

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London, ON N5V 1R9
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London InterCommunity Health Centre