Trans Health Referral Form

FAX: 519-642-1532
PHONE: 519-660-0874 ext. 1279
CLIENT MUST RESIDE IN LONDON, ON

Instructions

PRINT & FAX: 519-642-1532, OR
PRINT & EMAIL: TRANSHEALTH@LIHC.ON.CA

London InterCommunity Health Centre

Date:

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		Health Card (version code)	
Client provided verbal consent to participate in Trans Care at LIHC: ☐ Yes ☐ No			

PROVIDER INFORMATION (PROVIDER REFERRAL*)

Provider Name/ Family Doctor		Address	
Phone Number or Fax Number		Physician Signature	

SERVICES REQUESTED (Check All That Apply)

☐ Transition Related Counseling ☐ Medical Care (transition related only) ☐ Identification Support ☐ Social Support (Adult) - Outreach Worker ☐ Social Support (Youth) - Youth Outreach Worker ☐ Other – Please specify in notes	NOTES:

Reason for Referral*:

If the client is receiving care from other provider or is on a waitlist, please provide details:

Please note that once we receive this document, we will contact the patient to discuss service and program options.

*Self-referrals are only accepted from unattached patients. Attached patients require referral from their primary care provider.