Trans Health Referral Form

FAX: 519-642-1532
PHONE: 519-660-0875
CLIENT MUST RESIDE IN LONDON, ON

London InterCommunity Health Centre

Date:

CLIENT INFORMATION (SELF REFERRAL)			
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		Physician Name	
Client provided verbal consent to participate in Trans Care at LIHC:		☐ Yes	☐ No

PROVIDER INFORMATION (PROVIDER REFERRAL)			
Provider Name		Email Address	
Phone Number or Fax Number		Address	

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:

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 be in touch with you to discuss service and program options.

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