

Trans Health Referral Form

FAX: 519-642-1532

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CLIENT MUST RESIDE IN LONDON, ON

Date:

CLIENT INFORMATION (SELF REFERRAL)

Legal Name		Preferred Name	
Date of Birth		Spoken Language	<input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other: <input type="checkbox"/> Requires Interpreter
Phone Number	Consent to leave message <input type="checkbox"/>	Address with Postal Code	
Gender		Pronouns	
Email Address		Physician Name	
Client provided verbal consent to participate in Trans Care at LIHC:		<input type="checkbox"/> Yes	<input type="checkbox"/> No

PROVIDER INFORMATION (PROVIDER REFERRAL)

Provider Name		Email Address	
Phone Number or Fax Number		Address	

SERVICES REQUESTED (Check All That Apply)

<input type="checkbox"/> Mental Health / Social Support <input type="checkbox"/> Medical Care <input type="checkbox"/> Identification Support <input type="checkbox"/> Anonymous HIV testing <input type="checkbox"/> Hepatitis C Care <input type="checkbox"/> Youth Outreach Workers <input type="checkbox"/> Other – Please specify in notes	NOTES:
Reason for Referral:	

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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