Gender Care Referral Form Instructions

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

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 Assigned at Birth		Pronouns	
Affirmed Gender		Health Card (Include 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 Counselling ☐ Medical Care (transition related only) ☐ Identification Support ☐ Social Support (Adult) - Outreach Worker ☐ Social Support (Youth) - Youth Outreach Worker ☐ Other – Please specify in notes	NOTES:

Required:* Please provide consult letter including *CPP (Cumulative Patient Profile).

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.**

*As of April 1st, 2024, regretfully, we are unable to receive referrals for individuals under 16 years of age. Anyone under 16 years of age should be referred to the **Gender Pathways Program** at London Health Sciences Children's Hospital.