Trans Care BC
Provincial Health Services Authority

Hormone Readiness Assessment

Template

PATIENT INFORMATION			
Last name:		Name used:	
Name *(as appears on BC Services Card):*		Pronouns:	
PHN or UCI*:	Date of birth *(YYYY-MM-DD):*	☐ Under 18yrs?	
Address:			
City:	Province:	Postal code:	
Phone: Voicemail ok? ☐ *Yes* or ☐ *No*		Email:	
Primary language:	Interpreter required? ☐ *Yes* or ☐ *No*		
Emergency contact name:	Emergency contact phone:		

Any considerations regarding appointment booking?

PROVIDER DETAILS			
Provider name:	*I am the client's primary care provider*	MSP #:	
Clinical discipline:		Office phone:	
Mailing address:		Office fax:	
City:	Province:	Postal code:	Email:
Name of client's primary care provider: *(If different)*	Primary care provider phone:	Primary care provider fax:	

Other care providers involved *(e.g., specialists, support workers, mental health team):*
Please list name(s), organizations, phone numbers.

CLINICAL INFORMATION

Please list the dates you met with your client to discuss hormone readiness: ☐ Client seen via telehealth

1. What hormone therapy does your client wish to start? *Select all that apply.*

☐ Estrogen-based therapy
☐ Testosterone-based therapy
☐ Puberty blockers
☐ Other:

**Individuals covered by Interim Federal Health Program (IFHP) will have a Unique Client Identifier (UCI). Providers may apply to be an Approved Provider through IFHP to bill for care delivered to IFHP-covered patients. More information can be found at the webpage "Interim Federal Health Program – Information for health care professionals in Canada" on the Government of Canada website.*

2. **Please describe your client's gender journey, their experience of gender incongruence/dysphoria, and the impact of any other gender-affirming steps taken to date** *(e.g., changes in hairstyle or wardrobe, padding/packing/tucking, hair removal, name change, pronoun change):*

3. **Has your client previously taken hormones, either through prescription or self-access?**

4. **Please summarize your client's expectations, hopes and any concerns regarding hormone therapy:**

5. **Please describe any further gender affirming goals your client may have, either after or concurrently with hormones** *(e.g., specific surgeries):*

6. **Are there any communication or accessibility needs to be aware of?** *(e.g., interpreter, visual/audio aids, scent-reduced space)?*

7. **Provide a brief description of your client's past and current medical history, including:**

   a. **Physical health:** *List any diagnoses, treatment history and current status.*

   b. **Mental health:** *List any diagnoses, treatment history and current status.*

   c. **Age-specific factors for consideration:**

   d. **Current medications:** *Attach list if available.*

   e. **Please indicate if your client has past/current substance use that could impact their ability to start or maintain hormone therapy:** *If yes, please describe below.* ☐ *Yes* or ☐ *No*

   f. **Allergies:**

8. Describe your client's social situation *(e.g., housing, work, supports):*

9. Are there any physical, mental health or social concerns that need to be addressed prior to or during hormone initiation?

10. **Please describe conversations regarding fertility goals that you have had with your client, including how hormones could potentially impact future fertility, and if applicable, fertility preservation options:**

11. **Briefly summarize your assessment of the patient and the reasons you are recommending them for hormone therapy:**

REVIEW OF WPATH STANDARDS OF CARE 8 CRITERIA

The following criteria are applicable to ALL gender-affirming interventions:

☐ I confirm that I have reviewed potential effects and risks of hormone therapy. This does not replace the prescriber's informed consent process (if applicable).

☐ I confirm this client's gender incongruence/dysphoria is marked and sustained.

☐ I confirm the client meets diagnostic criteria for gender incongruence/gender dysphoria and have excluded other possible causes of apparent incongruence.

☐ I confirm this client understands the information provided and has the capacity to consent to the treatment(s) outlined above. If the client is under 19 years of age and deemed to be a mature minor according to the BC Infants Act, I confirm that in my opinion, they have the capacity to consent to treatment and treatment is in their best interest.

- "Evaluating Decision-Making Capacity for Gender-Affirming Interventions" tool available at the Trans Care BC Website *(Health Professionals – Clinical resources)*.

☐ I confirm that any physical and mental health conditions that could negatively affect the outcome of treatment for this client have been assessed, with risks and benefits discussed.

☐ I confirm that the client understands the potential impact of treatment on reproduction and/or infant feeding and have reviewed relevant options.

CONFIRMATION OF QUALIFICATIONS

Clinicians supporting clients with decisions regarding gender-affirming medical or surgical treatments should hold specific qualifications and competencies to assess readiness for gender-affirming care. WPATH SOC-8 suggests providers liaise with professionals from different disciplines for consultation and referral, when required.

☐ I confirm that I hold the following qualifications and competencies:

- I have a master's degree or equivalent training in a clinical field relevant to this role.
- I am licensed by a statutory body.
- I am able to identify mental health or psychosocial concerns and distinguish these from gender incongruence, dysphoria or diversity.
- I am able to assess capacity to consent.
- I have experience or am qualified to assess clinical aspects of gender incongruence, dysphoria and diversity.
- I engage in ongoing professional development relating to gender incongruence, dysphoria and diversity.

☐ I confirm that I hold the following additional competencies for working with youth: *(if relevant)*

- I have theoretical and evidenced-based training and expertise in general child, adolescent, and family mental health across the developmental spectrum.
- I have training and expertise in gender identity development, gender diversity in children and adolescents and possess general knowledge of gender diversity across the lifespan.
- I have training and experience in autism spectrum disorders and other neurodevelopmental presentations, or I collaborate with a developmental disability expert when working with autistic/neurodivergent gender diverse adolescents.
- I engage in ongoing professional development in all areas relevant to gender diverse children, adolescents, and families.

Healthcare providers can use the RACEapp+, eCase, or call the RACE Line at 604-696-2131 (toll-free: 1-877-696-2131) and select the "Transgender Health" option to consult with an experienced clinician.

CLINICIAN SIGNATURE

The above information is true to the best of my knowledge. I am available for coordination of care if needed.	Clinician signature:	Date *(YYYY-MM-DD):*