Trans Care BC
Provincial Health Services Authority

Referral for Upper Surgery

Fax completed form to 604-297-9900
Questions call 1-866-999-1514

Incomplete forms will be returned. See page 2 for instructions & resources.

TCBC OFFICE USE ONLY	**Surgeon assigned:**
Referral Priority DATE (YYYY-MM-DD)	

PATIENT INFORMATION

Last name:	Name used:	
Name *(as appears on BC Services Card):*	Pronouns:	
PHN:	Date of birth *(YYYY-MM-DDD):*	☐ Under 18yrs?
Address:	Province:	Postal code:
City:	Is patient a Canadian citizen or permanent resident? ☐ *Yes* or ☐ *No*	
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?		

REFERRAL DETAILS

Reason for Referral *(select one)*	☐ Chest construction (mastectomy & contouring) ☐ Breast construction (augmentation) ☐ Chest reduction ☐ Other (describe): ☐ Revisions (describe):
Diagnosis of Gender Incongruence/ Dysphoria	Have you or any other **qualified** provider confirmed a diagnosis of gender incongruence/ dysphoria for this patient? ☐ *Yes* or ☐ *No* *MD/NP and some allied health providers are qualified to diagnose. See pg. 2 for guidance.*
Surgical Readiness Assessment	☐ Completed surgical readiness assessment is attached. *MD/NP and some allied health professionals (master's-level clinicians whose scope of practice include surgical readiness assessment) can complete a surgical readiness assessment for top surgeries. See pg. 3 for template.* **OR** ☐ Please coordinate an appointment for surgical readiness assessment for this patient. **Client open to completing assessment with regional gender clinic, where available?** ☐ *Yes* or ☐ *No*

Height: **Weight:** **BMI:** ☐ **Sleep apnea** – If checked: CPAP therapy? ☐ *Yes* or ☐ *No*

Length of time on hormone therapy:
(Referrals for breast construction only; start date or number of months/years.)

Any concerns regarding the stability of your patient's physical or mental health?	☐ *No*	☐ *Yes,* **SEE ATTACHED**
Any medical or surgical history?	☐ *No*	☐ *Yes,* **SEE ATTACHED**
Any current medications and/or allergies?	☐ *No*	☐ *Yes,* **SEE ATTACHED**
Any psycho-social concerns that may impact treatment?	☐ *No*	☐ *Yes,* **SEE ATTACHED**
Any substance use (including tobacco, cannabis, other)?	☐ *No*	☐ *Yes,* **SEE ATTACHED**
A history of physical or verbal aggression?	☐ *No*	☐ *Yes,* **SEE ATTACHED**

REFERRING PROVIDER

Name: MSP #:	Office address: Phone: Fax: Date *(YYYY-MM-DD):*
Primary care provider:	*If available, place office information Label or Stamp*
Signature:	

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Upper Surgery Central Waitlist: Information for Patients & Providers

Surgeons require a copy of the surgical readiness assessment in addition to this referral form. **Trans Care BC will only forward the complete referral package to the surgeon's office AFTER the surgical readiness assessment has been received and/or completed.**

1. **Complete form** in collaboration with your patient.
2. **Include the following information:**

   ☐ Current BMI
   ☐ Medical history
   EITHER:
   ☐ Completed surgical readiness assessment *(if available. See form below)*
   OR: ☐ Check box on page 1, *"Please coordinate an appointment for surgical readiness assessment for this patient."*
3. **Trans Care BC will send a receipt** to the referring provider in 2–4 weeks.
4. **Trans Care BC will contact the patient** to review and confirm surgeon choice, and forward complete referral package.
5. **The surgeon's office will** contact the patient **or** referring provider to set up an appointment.
6. **Referring or primary care provider** (if different) to support post-operative care.

SURGEONS WORKING FROM THE CENTRALIZED WAIT LIST

- Please send your completed package to TCBC. Our Upper Surgery team will review eligible surgeon options and wait times with the patient and forward the completed package to the patient's surgeon of choice.

SUPPORT FOR DIAGNOSIS OF GENDER INCONGRUENCE/DYSPHORIA

- Use RACEapp+ and select the "Transgender Health" option to consult with an experienced clinician
- Contact the RACE line at 1-877-696-2131
- Contact eCASE at ecase@providencehealth.bc.ca

IMPORTANT NOTES REGARDING BREAST CONSTRUCTION (BREAST AUGMENTATION)

- Breast construction is publicly funded only under certain circumstances. A plastic surgeon must submit a funding application to MSP prior to surgery.

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Surgical Readiness Assessment

Template – Upper Surgery or Gonadectomy

PATIENT INFORMATION			
Last name:		Name used:	
Name *(as appears on BC Services Card):*		Pronouns:	
PHN:	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 gender-affirming surgery: ☐ Client seen via telehealth

1. For which surgery or surgeries are you referring your client? *Select all that apply.*

UPPER SURGERY
- ☐ Chest reduction & construction *(mastectomy & contouring)*
- ☐ Breast construction *(augmentation)*

GONADECTOMY
- ☐ Hysterectomy *(with or without oophorectomy)*
- ☐ Orchiectomy *(with or without scrotectomy)*

OTHER
- ☐ Other surgery:

2. **Please describe your client's gender identification, their experience of gender incongruence/dysphoria, and the impact of any other gender-affirming steps taken to date** *(e.g., hormone therapy, hair removal, name change):*

3. **Has your client taken hormones? If so, please describe details of treatment below:**
   Please list start date, duration, significant breaks. Please note if hormone therapy is not clinically indicated.

4. **Summarize your patient's expectations regarding surgery:**

5. Are there any communication or accessibility needs the surgeon should be aware of *(e.g., interpreter, visual/audio aids, support person/worker)?*

6. 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.*

Height: **Weight:** **BMI:** ☐ **Sleep apnea** – If checked: CPAP therapy? ☐ *Yes* or ☐ *No*

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

c. Surgical history:

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

e. Please indicate if your client has past/current substance use that would affect their perioperative experience: *If yes, please describe below.* ☐ *Yes* or ☐ *No*

f. Allergies:

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

8. Do you anticipate your client will have stable housing and adequate support to facilitate healing during the post-op period? *If no, please explain how this will be managed below.* ☐ *Yes* or ☐ *No*

9. Do you believe your client is capable of carrying out their after care plan *(e.g., reducing activities, managing drains/compression vest)? If no, please explain how this will be managed below.* ☐ *Yes* or ☐ *No*

10. Briefly summarize your conversation with the patient regarding impacts to fertility and/or infant feeding:

11. Briefly summarize your recommendation:

REVIEW OF WPATH STANDARDS OF CARE 8 CRITERIA

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

☐ I confirm that I have reviewed with the client the procedure(s) indicated above.

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

☐ I confirm the client meets diagnostic criteria for gender incongruence/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, 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 mental health and physical 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 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 surgeries. 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.

Select one:

☐ I am competent using ICD (or alternative) to diagnose gender incongruence/dysphoria.

- A diagnosis of gender incongruence/dysphoria is required prior to gender-affirming medical or surgical treatments.
- Any physician or nurse practitioner is qualified to make these diagnoses, although some may feel they lack relevant training and experience.

☐ I am a clinician whose scope of practice does not include the ability to diagnose gender incongruence/dysphoria. However, I have experience care planning for clients seeking gender-affirming medical or surgical interventions and providing recommendations for treatment. If needed, I will assist my client in connecting with a clinician who is qualified to diagnose gender incongruence/dysphoria.

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):
I confirm this person meets criteria for gender incongruence based on this assessment.	MD/NP signature (if needed):	Date (YYYY-MM-DD):