Trans Care BC
Provincial Health Services Authority

Surgical Readiness Assessment

Template – Genital surgery

Assessment for genital surgery must be done by a medical provider on Trans Care BC's list of approved clinicians.

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:

SELECT ONE: ☐ I or my team are able to provide **direct** pre- and post-operative care (in collaboration with the surgical team). **OR** ☐ I or my team are able to provide **consultation** to the primary care and surgical teams during the pre- and post-operative period.

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.*

☐ Vaginoplasty (minimal depth)
☐ Vaginoplasty (full depth)
☐ Vulvoplasty
☐ Phalloplasty
☐ Metoidioplasty
☐ Erectile tissue (clitoral) release
☐ Surgery revisions (describe):

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)?*

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: ☐ *Yes* or ☐ *No*
If yes, please describe below.

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., dilation, managing a catheter)? 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:

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.
- ☐ 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 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. **Assessment for genital surgery must be done by a medical provider on Trans Care BC's list of approved clinicians.** A list of qualified clinicians can be accessed through Trans Care BC.

☐ 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.
- ☐ 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):
Recommendations completed by RNs must be co-signed by a MD or NP who is also on Trans Care BC's list of clinicians qualified to provide care planning for genital surgery.	MD or NP co-signature:	Date (YYYY-MM-DD):