**West of England Specialist Gender Identity Clinic**

**GP Referral Form**

Please return this completed form and any additional documents via email marked for the attention of the Referrals Team to dpn-tr.thelaurels@nhs.net.

Alternatively, this can be sent via post to: Referrals Team

 The West of England Gender Identity Clinic

 The Laurels

 11-15 Dix’s Field

 Exeter

 EX1 1QA

**Please be advised we can only accept referrals from any GP in England for people aged 17 and above with Gender Dysphoria.**

If your patient is under 17 years of age, please contact The Arden & Greater East Midlands Commissioning Support Unit (Arden & GEM CSU)

Email: agem.cyp-gnrss@nhs.net

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| **Date of Referral** | **\_ \_ / \_ \_ / 20\_ \_** |

**Patient Details (Boxes marked with \* are a required field)**

**It is really important your patient keeps us updated if any of their details change. Please ask them to let us know as soon as possible so we can update our records.**

**Please be aware your patients name will show in the address on the outside of the envelope of any correspondence we send to them. Anyone delivering their post or anyone at their address will be able to see it on the outside of the envelope. If your patient is open to any other DPT service they will use your patients changed name in any correspondence or contact they have with the patient. Preferred names will only be used within the text of any correspondence unless we are advised otherwise.**

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| --- | --- | --- | --- | --- | --- |
| **\*Surname:** |  | **First Name:** |  | **Title:** |  |
| **\*NHS Number** |  | **\*Date of Birth** |  | **Age** |  |
| **How does the person you are referring describe their gender identity?** |  |
| **Is this different from that which they were assigned at birth?** | Yes [ ]   | No [ ]   | Prefer not to answer [ ]  |

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| --- | --- | --- | --- |
| **\*Address:** |  | **Correspondence Address (if different):** |  |
| **\*Telephone:** |  | **\*Email:** |  |
| **\*Any instructions re contact, e.g. use of name and pronouns, how you would like correspondence to be addressed.** |  |

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| **Emergency contact name & relationship:** (this is for emergencies only, we will not contact this person to discuss patient gender care) |  | **Emergency contact telephone number:** |  |
| **Main language spoken:** |  | **If an interpreter is required please tell us what language,** |  |
| **Does the patient have any communication, sensory or mobility needs?** | Yes [ ]   | No [ ]   | **If yes, please tell us** |  |
| **Is the patient able to attend the clinic independently?** | Yes [ ]   | No [ ]   | **If no, please give more information** |  |

**GP Details**

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| **GP Practice Name:** |  | **GP Name:** |  |
| **GP Address:** |  |
| **GP Email:** |  | **GP Telephone:** |  |

**Referrers Details** *only if the referrer is not the patient’s GP*

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| **Name:** |  | **Professional Role:** |  |
| **GP Address:** |  |
| **Email:** |  | **Telephone:** |  |

**Text Reminder Service**

Our service would like to contact your patient via text message to remind them of any upcoming appointments with our clinic. This is a free service and they will not be charged for receiving any appointment reminders. Please could you ask your patient to indicate below if they consent to receiving text messages from our service..

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| **\*Do you give consent to receive text reminders?** | Yes [ ]  | No [ ]  |

**Health**

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| --- | --- | --- | --- |
| **Height (m):** |  | **Weight (kg):** |  |
| **Does the patient smoke?** | YES [ ]  | NO [ ]  | Amount: |
| **Alcohol consumption?** | YES [ ]  | NO [ ]  | Amount: |
| **Recreational drug use?** | YES [ ]  | NO [ ]  | Amount: |

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| **Does the patient have a mental health or learning difficulty?** |
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| **Does the patient have a formal diagnosis Neurodiversity? (diagnoses or suspected) E.g. autism, ADHD, dyslexia, dyspraxia etc.** |
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| **Does the patient have any current and / or past risk of self-harm and / or suicidality:** |
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| **\*Does the patient have any current and/or past risk of harm to others and/or forensic history.** |
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**Other**

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| **Is the patient currently receiving support from any other agencies? E.g. Social care, Mental Health Team, Probation.** (please provide names and contact details) |
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| **Is there any other relevant information or anything else that you think is important for us to know?** |
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**Referral Details**

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| **Please provide information regarding the following;*** **Development and duration’s of your patient’s gender concern**
* **The impact upon their psychological wellbeing and social functioning**
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| **\*Has you patient attended this clinic previously?** | YES [ ]  | NO ☐ |
| **\*Has the patient attended another Gender clinic previously, if yes, which? (please include private gender clinics)** | Yes at; | NO [ ]  |
| **Please provide details of any previous or current treatment with another Gender Service** |
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**If your patient is currently receiving care from one of the other NHS Gender Identity Services please contact them to transfer your patient’s care to us. We cannot accept this referral as a transfer of care**

**Further Information**

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| **Ethnicity:** |
| Asian – Bangladeshi | [ ]  | Black – Caribbean | [ ]  | Mixed – White/Black African | [ ]  |
| Asian - Indian | [ ]  | Black – Other | [ ]  | Mixed – White/Black Caribbean | [ ]  |
| Asian – Kashmiri | [ ]  | White – Other | [ ]  | Other ethnic group | [ ]  |
| Asian – Other | [ ]  | Chinese | [ ]  | White - British | [ ]  |
| Asian - Pakistan | [ ]  | Mixed – Other | [ ]  | White - Irish | [ ]  |
| Black – African | [ ]  | Mixed – White & Asian | [ ]  | Declined to Answer | [ ]  |
| **Religion:** |
| Agnostic | [ ]  | Jain | [ ]  | Pagan | [ ]  | Hindu | [ ]  |
| Buddhist | [ ]  | Jewish | [ ]  | Sikh | [ ]  | Muslim | [ ]  |
| Christian | [ ]  | Jehovah’s Witness | [ ]  | Other | [ ]  | Declined to answer | [ ]  |
| **Marital / Civil Status:** |
| Divorced | [ ]  | Separated | [ ]  | Surviving Partner | [ ]  |
| Married/Civil Partner | [ ]  | Single | [ ]  | Declined to answer | [ ]  |
| **Living Status:** |
| Live alone | [ ]  | Live with parent guardian | [ ]  | Currently living in residential care | [ ]  |
| Live with family | [ ]  | Live with spouse/partner | [ ]  | Currently living in supported living | [ ]  |
| Live with other(s) | [ ]  | Of no fixed abode | [ ]  | Declined to answer | [ ]  |

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| **Accommodation Status:** |
| Bail/probation hostel | [ ]  | Other mainstream housing | [ ]  | Sheltered housing | [ ]  |
| Non-M/H. reg. care home | [ ]  | Owner occupier | [ ]  | Squatting | [ ]  |
| Older persons nursing home | [ ]  | Settled mainstream (live with family/friend) | [ ]  | Staying with family/friend | [ ]  |
| Other – homeless | [ ]  | Shared ownership scheme | [ ]  | Supported lodging | [ ]  |
| **Employment Status:** |
| Employed Full Time  | [ ]  | Employed Part Time | [ ]  | Student | [ ]  |
| Unemployed – seeking work | [ ]  | Unemployed – not seeking work | [ ]  | Unpaid/Voluntary | [ ]  |
| Looking after family/home | [ ]  | Unemployed – sick/disabled | [ ]  | Retired | [ ]  |
| Other | [ ]  |  |  |  |  |

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| **Sexuality:** |
| Heterosexual or straight | [ ]  | Gay or lesbian | [ ]  | Other sexual orientation not listed | [ ]  |
| Decline to answer | [ ]  | Bisexual | [ ]  | Do not know/unsure | [ ]  |