**Referral Form for Leeds Gender Identity Service**

**Newsam Centre, Seacroft Hospital, Leeds.**

**PLEASE NOTE:**

* Please ensure that the information you provide is up-to-date and correct. If the individual is screened as appropriate to be accepted onto the Gender ID pathway then is it their responsibility to inform us of any changes to their situation, this includes changes of address and contact details.
* If any of the following details are not fully completed then the referral cannot be processed.
* This referral form must be completed electronically and then submitted to the following email address: gid.lypft@nhs.net. We cannot accept postal referral forms.
* More information about the service can be found on the following webpage: <https://www.leedsandyorkpft.nhs.uk/our-services/services-list/gender-identity-service/>

|  |  |
| --- | --- |
| **Date of referral**  |  |
| **Patient’s name** |  |
| **Preferred name and pronouns** |  |
| **Date of birth** |  |
| **NHS Number**  |  |
| **Patient’s address** |  |
| **Preferred telephone number** |  |
| **Sex assigned at birth: Male or Female** |  |
| **Name of registered GP** |  |
| **GP contact details** | Address:Telephone: |
|  |

**Detailed reason for referral:**

|  |
| --- |
|  Has there been any previous input from a Gender ID service? Yes / No (If ‘Yes’, please provide any relevant documentation. |

1. **Medical history**

Please tick to say whether the patient is suffering from or has suffered from the following:

|  |  |  |  |
| --- | --- | --- | --- |
| Hypertension |[ ]  Stroke | [ ]  | Hormone imbalance |[ ]
| Genetic disorder |[ ]  Major surgery | [ ]  | Diabetes |[ ]
| Allergies | [ ]  | Heart attack | [ ]  | Cardiovascular disease |[ ]
| Thrombosis |[ ]  Endometriosis |[ ]  Breathing difficulties |[ ]
| Epilepsy |[ ]  Polycystic ovary syndrome |[ ]  Other |[ ]

|  |
| --- |
| Please provide additional information for any conditions that have been ticked. |

|  |
| --- |
| Please list all current medications (physical and psychiatric) and the dose |

Current BMI: \_\_\_\_\_\_\_\_\_\_\_

Please also attach a summary of the medical history with the referral

1. **Mental health and other diagnosis**

Please note we are not a mental health service. If you feel the patient requires support around their mental health please consider referral to local services. Please include any mental health reports/assessments.

Please tick to say whether the patient is or has suffered from the following:

|  |  |
| --- | --- |
| Depression |[ ]  Anxiety / anxiety disorders |[ ]
| Psychosis (incl. Schizophrenia) |[ ]  Schizoaffective disorder  |[ ]
| Bipolar disorder |[ ]  Mania |[ ]
| Body dysmorphic disorder (BDD) |[ ]  Eating disorder |[ ]
| Personality disorder |[ ]  Obsessive compulsive disorder |[ ]
| Suicidal thoughts  |[ ]  Suicide attempts |[ ]
| Alcohol misuse |[ ]  Substance misuse |[ ]
| Other mental health diagnosis |[ ]  Any mental health agencies involved |[ ]

|  |  |
| --- | --- |
| Learning difficulty/Intellectual disability |[ ]  Autism |[ ]
| Attention deficit hyperactivity disorder (ADHD) |[ ]   |  |

|  |
| --- |
| Please provide additional information for any diagnosis that have been ticked. |

1. **Risk**

Please tick below to indicate a current and/or historical risk

|  |  |  |
| --- | --- | --- |
| Risk of self-harm |[ ]  Risk to others |[ ]  Risk from others |[ ]
| Risk to children |[ ]  Risk of suicide |[ ]  Risk of self-neglect |[ ]
| Forensic/Prison history |[ ]  Any safeguarding concerns |[ ]  Other |[ ]

|  |
| --- |
| Please provide additional information for any risks that have been ticked.  |

1. **Further information**

|  |
| --- |
| Please provide any further relevant information including copies of relevant assessments or correspondence from other agencies involved in the person’s care (e.g. social services, community mental health team etc.) |

**Leeds GIS will consider initiating hormone treatment and recommend prescriptions and monitoring following a diagnosis made by this service. When making the referral, please note the requirements regarding GP’s commitment to hormone treatment and on-going prescribing, monitoring and review once patients are discharged from the hormone service.**

|  |  |
| --- | --- |
| **Referrer’s signature (Digital image files can be pasted in box to right)** |  |
| **Referrer’s name and address** |  |

Please email completed forms to Leeds Gender Identity Service at: gid.lypft@nhs.net

**Please ensure the demographic data form below is completed in full and included with the referral form. It will not be possible to process your referral without this demographic information.**

**DEMOGRAPHIC DATA**

|  |  |
| --- | --- |
| Name of patient  |  |
| Date of birth |  |
| NHS Number  |  |
| Sex assigned at birth: male or female |  |
| Main language spoken |  |
| Interpreter needed? Yes or No |  |
| Are there any communication, sensory or mobility needs? |  |

**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 Pakistani |[ ]  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 STATUS:**

|  |  |  |
| --- | --- | --- |
| Divorced  |[ ]  Separated |[ ]  Surviving partner |[ ]
| Married / civil partner |[ ]  Single |[ ]  Declined to answer |[ ]

**LIVING STATUS:**

|  |  |  |
| --- | --- | --- |
| Lives alone |[ ]  Lives with parent/ guardian |[ ]  Residential care |[ ]
| Lives with family |[ ]  Lives with partner/ spouse |[ ]  Supported living |[ ]
| Lives with other |[ ]  No fixed abode |[ ]  Client declined to answer |[ ]

**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/friends |[ ]
| Other – Homeless |[ ]  Shared Ownership Scheme |[ ]  Supported lodging |[ ]

**EMPLOYMENT STATUS:**

|  |  |  |
| --- | --- | --- |
| Employed F/T |[ ]  Employed P/T |[ ]  Student |[ ]
| Unemployed – Seeking work |[ ]  Unemployed – Not seeking work |[ ]  Unpaid/Voluntary |[ ]
| Looking after Family/ Home |[ ]  Unemployed – Sick / Disabled |[ ]  Retired |[ ]
| Other |[ ]   |  |  |  |

**SEXUALITY:**

|  |  |  |
| --- | --- | --- |
| Heterosexual or Straight |[ ]  Gay or Lesbian |[ ]  Other sexual orientation not listed |[ ]
| Declined to answer |[ ]  Bisexual |[ ]  Person does not know / unsure |[ ]

**SMOKING STATUS:**

|  |  |
| --- | --- |
| Does client smoke? | YES / NO |
| If yes, have they been offered help via smoking cessation? | YES / NO |
| If help was offered, did they accept this help? | YES / NO |
| Date that this was offered? |  |