**Referral Form for Leeds Gender Identity Service**

**PLEASE NOTE:**

This referral form must be completed electronically and then submitted to the following email address: [gid.lypft@nhs.net](mailto:gid.lypft@nhs.net).

We would request that you do not send the referral by post as this will lead to delays in processing.

**NHS Number**

Please note that if you/your patient decides to change their NHS number whilst they are waiting, this may mean that we no longer have access to their information or referral, so this may cause difficulties in offering an appointment. We would ask that you/your patient contacts the service to inform of the change, giving the service permission to link old and new NHS numbers to prevent any delays in care.

**Guidance for Self-Referral**

The service accepts self-referrals. The preferred method is completion of this referral form. When we acknowledge the referral we will copy in both the patient and the GP into the acknowledgement letter. It is important that the GP is aware of the referral as they will be required to support the patient whilst in the service and post discharge, particularly in relation to continuing to prescribe and monitor hormone treatment long-term.

Please note that breast augmentation, thyroid chondroplasty (tracheal shave) or cricothyroid approximations (vocal pitch) are not currently funded by NHS England. If you are requesting a review of current hormone treatment only, please be aware that we do not offer monitoring and that it may be more appropriate to refer to a local endocrinologist for review.

|  |  |
| --- | --- |
| **Date of referral** |  |
| **Is this a self-referral?** |  |
| **Patient’s name** |  |
| **Preferred name and pronouns** |  |
| **Name to be used for correspondence** |  |
| **Date of birth** |  |
| **NHS Number** |  |
| **Patient’s address** |  |
| **Telephone number** |  |
| **How would you describe your gender identity?** |  |
| **Sex assigned at birth: Male or Female** |  |
| **Name of registered GP** |  |
| **Address of GP** |  |

**Detailed reason for referral: What treatments are you seeking?**

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

1. **Medical history**

Please tick to say whether you/the patient has experienced any of 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. |

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| --- |
| Please list all current medications and the dose |

Current BMI: \_\_\_\_\_\_\_\_\_\_\_ If unknown please provide weight\_\_\_\_\_\_\_\_\_\_\_\_ and height \_\_\_\_\_\_\_\_\_\_\_\_

If this referral is being made by the GP, please also attach a summary of the medical history.

1. **Mental health and other diagnosis**

Please note we are not a mental health service. If you/your patient requires support around their mental health please consider referral to local services or approaching your GP for local support. Please include any mental health reports/assessments if available.

Please tick to say whether the you/your patient has experienced or lives with 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 information including copies of relevant assessments or correspondence from other agencies involved in the your/your patient’s care if relevant (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 the GP’s commitment to hormone treatment and on-going prescribing, monitoring and review once patients are discharged from the hormone service. If you are self-referring please discuss this requirement with your GP as if they are not in agreement with long-term prescribing and monitoring this may affect future care.**

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

**Please ensure the demographic data form below is completed in full and included with the referral form.**

Leeds GIS, Management Suite, Newsam Centre, Seacroft Hospital Site, York Road, Leeds, LS14 6WB

**DEMOGRAPHIC DATA**

|  |  |
| --- | --- |
| Name of patient |  |
| Date of birth |  |
| NHS Number |  |
| 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 the patient 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? |  |