Referral to the Transgender Clinic at Groote Schuur Hospital

Date of Referral:	

Patient Details:					
Legal Name:			**D.O.B:**		
Chosen name: **Chosen pronouns:**			**Sex assigned at Birth**	Female	Male	Intersex
Address:			**Hospital number:**		
Patient Telephone:			**Patient Email:**		
Interpreter Required?	☐ Yes	☐ No	**If required, what language?**		
Can patient attend clinic independently?	☐ Yes	☐ No	**If no, please give more information**		

Referrers Details:			
Referrer Name		**Referrer Job Title:**	
Referrer Address		**Referrer Telephone:**	
Referrer Email:		**Referrer Fax:**	

Detailed reason for referral:

Has the patient made a social role/ medical/ surgical and/or legal transition to their self-identified gender identity?	☐ Yes	☐No	Comment:

Medical and Surgical History:

Current medications (prescribed and non-prescribed) including hormones, contraceptives and herbal medicines:			
Name:	**Dose:**	**Prescribed by/ obtained from:**	**Duration:**

Mental health background (any diagnosed or suspected mental health concerns) including current and previous mental health treatment:

Any other agencies involved:

Forensic /legal history:

Any other relevant information or comments:

Referrer's Signature:	**Referrer's Job Title:**	**Date:**

Please return this form to:

GSH Transgender Clinic
J2 OPD Psychiatry - Groote Schuur Hospital
Tel: 021 404 2151
Fax: 021 404 2153
Email: GSH.PsychOPD@westerncape.gov.za