Hôpital de Montréal pour enfants
Centre universitaire de santé McGill

Montreal Children's Hospital
McGill University Health Centre

Gender Variance Clinic
Referral Form

1001, boul. Décarie, Room A04-3140, Montreal, Québec, H4A 3J1
Telephone: (514) 412- 4496 Fax: (514) 412- 4136
Email: bdbci@muhc.mcgill.ca

Referral date (yyyy/mm/dd):

Patient Information (please print):

Date of birth (yyyy/mm/dd):	**MCH File no.** / **RAMQ :**
Last name, First name	
Current address **City, Province** **Postal Code**	
Home telephone number	**Other telephone number**
Email	**Language** ☐ French ☐ English Other: _____ ☐ Interpreter needed

Please specify the following: ***NB if child does not meet this criteria, please redirect the request to the patient's local CIUSSS / CISSS or Hospital Centre (E.g., Ste-Justine, CHUL, CHUS)***

☐ Child / adolescent resides within one of the following McGill RUISSS sectors: *Nunavik, Outaouais, Cree Territory, West-Central Montreal and the West Island of Montreal, Nord du Québec, Montérégie-Ouest, Abitibi-Temiscamingue*

AND/***OR***

☐ Child / adolescent is actively followed by related tertiary service(s) at MCH (*e.g. Neurology, Psychiatry, Oncology, etc.*), *specify*: _____

Please describe your concerns and age of patient at referral:

Please attach any additional information on a separate page.

Please specify the following: ****NB for children under age of 8 yrs please redirect the request to the patient's local CIUSSS / CISSS for psychosocial and/or mental health services as appropriate***

☐ Patient age **0-13 yrs**

☐ Patient **age 14 yrs or over**: ☐ authorizes our clinic to contact parent/guardian about referral & appointment

☐ **does NOT** authorize contact with parent/guardian, **Please provide direct contact info. for patient:**

Patient Cell (____) _____ - _____ Patient Email:_____

☐ Patient's preferred first name & preferred pronouns (If applicable): _____

☐ Please list any diagnosis(es), medical condition(s) and/ or complex psychosocial situations (e.g. DYP involvement):
*Specify:*_____

_____

☐ Current medications, *specify*: _____

Please indicate if child is on the wait list for or currently followed by these community services: ***Please specify name & coordinates and provide reports if applicable***

☐ **Youth Protection Services** (e.g. DYP / Batshaw) *Please provide name & coordinates of delegate(s):*

_____

☐ **CRDI-TSA** (Centre de réadaptation en déficience intellectuelle et Trouble du spectre de l'autisme), specify::

_____

☐ **CLSC / CIUSSS** (e.g.,psychosocial, mental health services, sexologist, psychoeducation, counselling ,etc.), *specify*:

_____

☐ **Child Psychiatry** (Hospital center, private, etc), *specify & provide report if applicable:*

_____

Referral Source:

Name of Referring Physician or Nurse Practitioner (please print):	License number:
Address:	
Telephone number:	Fax number:
Name of Treating Physician (if different):	

PARENT(S) AND PATIENT OR PATIENT OVER 14 YRS. ARE INFORMED OF THIS REFERRAL AND AGREE ☐

REFERRING PROFESSIONALSIGNATURE::