

REFERRAL LETTER FOR TRANSGENDER CARE

CENTRE FOR SEXOLOGY AND GENDER

T +32 (0)9 332 60 23 | E gender.aanmelding@uzgent.be

Dear colleague,

With this form, as a clinical psychologist or psychiatrist, you can refer your client aged over 24 to the medical departments at UZ Gent that provide transgender care. No psychological assessment or follow-up is carried out by the Centre for sexology and gender; the client will be referred directly to a medical department.

May we ask you to complete a separate form for each gender-affirming step?

The referral provided in this form is valid for 6 months.

Based on the information in the form, your client will be assigned an appropriate care pathway. This may also mean that direct access to care is not possible. If there are any questions or uncertainties, we will contact you.

This document will become part of your client's electronic patient record at UZ Gent.

SUBMITTING THE REFERRAL LETTER

- You can send us the completed letter via our centre's eHealthbox: Centrum voor seksuologie & gender - U.Z. GENT (71067049).
- Your client can also send us the letter together with the [registration form](#).

Kind regards,

Centre for sexology and gender

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REFERRER DETAILS

First name: _____

Last name: _____

Telephone number: _____ Email address: _____

Professional qualification: _____

Professional registration number (INAMI, visa, etc.): _____

CLIENT DETAILS

First name: _____

Last name: _____

Chosen name (if different from the legal name): _____

Telephone number: _____ Email address: _____

National register number (or BIG registration number): _____

Is the client Dutch-speaking? ☐ Yes ☐ No, native language is: _____

General practitioner

First name: _____

Last name: _____

Municipality: _____

REFERRAL

The client is being referred for (*):

☐ Hormone treatment

☐ Oophorectomy

☐ Phalloplasty

☐ Mastectomy

☐ Colpectomy

☐ Vaginoplasty

☐ Breast augmentation

☐ Orchiectomy

☐ Gender-affirming facial surgery

☐ Hysterectomy

☐ Metoidioplasty

☐ Voice surgery

☐ Other: _____

(*) Please select one treatment only. Complete a separate form for each additional treatment.

▲ REPORT OF THE TRANSITION PROCESS AND THE REQUEST FOR CARE

Provide a brief summary of any previous social and medical steps related to gender identity.

Briefly describe the motivation for the requested intervention.

▲ SUMMARY OF THE PSYCHOLOGICAL ASSESSMENT

Description of gender identity and gender development.

Mental health, including any diagnoses.

Duration and frequency of the relationship between the mental health professional and the client, including the type of support, therapy, or counselling provided to date.

Daily activities: education, professional activities, or other occupations.

All relevant social factors, such as social integration and networks, level of support, position within or contact with the family of origin, and partnerships.

▲ REPORT OF MEDICAL HISTORY AND PHYSICAL HEALTH

Provide a brief statement of any other relevant medical aspects considered necessary for the medical request.
Please take into account alcohol consumption, smoking, BMI, medication, allergies, etc.

▲ DECLARATION FOR THE INITIATION OF HORMONE THERAPY

As the referring professional, I confirm (please tick as applicable):

- ☐ My client experiences marked and persistent gender incongruence.
- ☐ Other possible causes of apparent gender incongruence have been identified and excluded.
- ☐ My client demonstrates the capacity to provide informed consent for the specific gender-affirming hormone treatment.
- ☐ Mental health and physical conditions that may negatively affect the outcome of treatment have been assessed.
The risks and benefits have been discussed.
- ☐ My client understands the impact of gender-affirming hormone treatment on fertility. Reproductive options have been explored.

▲ DECLARATION FOR GENDER-AFFIRMING SURGERY

As the referring professional, I confirm (please tick as applicable):

- ☐ My client experiences marked and persistent gender incongruence.
- ☐ Other possible causes of apparent gender incongruence have been identified and excluded.
- ☐ My client demonstrates the capacity to provide informed consent for the specific gender-affirming surgical procedure.
- ☐ Mental health and physical conditions that may negatively affect the outcome of the gender-affirming surgical procedure have been assessed. The risks and benefits have been discussed.
- ☐ My client understands the impact of the gender-affirming surgical procedure on fertility and has explored reproductive options.
- ☐ My client is stable on the gender-affirming hormone treatment regimen (hormone treatment for at least 12 months, or longer if required to achieve the desired surgical outcome, unless hormone therapy is not desired or is medically contraindicated).

If gender-affirming hormone treatment or gonadal suppression is not clinically indicated, or if the procedure does not align with the wishes, goals, or expression of the patient's individual gender identity, please provide an explanation below.

▲ COMMENTS

Do you have any questions or comments?

▲ DECLARATION

- ☐ I confirm that I have reviewed this referral letter with my client.
- ☐ I declare that I remain available to my client for further follow-up and aftercare related to the care request described above.
- ☐ I am available for consultation regarding my client with the members of the UZ Gent gender team through:
 - ☐ Email: _____
 - ☐ Telephone, preferably at the following times: _____

▲ REFERRING PROFESSIONAL

Date ____ / ____ / ____

Signature