The Royal Children's Hospital Melbourne

FRC1002025

RCH Gender Service Referral

Fax all referrals to (03) 9345 5034
Telephone enquires (03) 9345 6180 (Monday – Friday 8:15am – 4:15pm)

Please note: A typed referral is required.

Receipt of referral and rejection notifications will be via fax within 8 working days.

Families will receive SMS confirming receipt of referral (mobile number MUST be included).

Correspondence will be sent to the family when the patient is added to the waiting list or appointment is offered.

Gender Service Intranet link:
www.rch.org.au/adolescent-medicine/gender-service/

Patient Details

Legal Name		**Preferred Name**
Date of birth	**Age**	**RCH UR number** *(If known to hospital)*
Sex assigned at birth	**Preferred Gender**	**Preferred Pronouns**
Address		**Postcode**
Please ensure that referrals to the Gender Service include all requested information. Adolescents 16 years or under require a parent to be aware of the appointment and to attend with them.		
Parent/Carer's name		**Phone number**
Does patient speak English? ◉ **Yes** ○ **No**		**If not what is the primary language?**

Prior to referral please ensure community based mental health support is in place.

Mental Health

Is the patient seeing a mental health provider? ○ **Yes** ○ **No**
Contact details of mental health provider
If no mental health provider have you provided a mental health care plan? ○ **Yes** ○ **No**

Pubertal Status estimate is required (blood tests are not required)

○ **Birth assigned female:**	○ **Pre menarche**	○ **Post menarche**
○ **Birth assigned male:**	○ **Voice deepened**	○ **Voice not deepened**

Reason for referral to RCH Gender Service

Referral Agency Information

Name	**Referral duration**
Service	○ 3 months
Position **Provider Number**	○ 12 months
Telephone number **Fax number**	
Doctor's signature **Date: / /**	

October 2021