The Royal Children's Hospital Melbourne

RCH Gender Service Referral

Fax all referrals to (03) 9345 5034
Telephone enquires (03) 9345 6180 (Monday – Friday 8:30am – 5:00pm)

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 First Name		**Legal Surname**	
Chosen First Name		**Date of birth**	**Age**
Medicare Number ___ ___ ___ ___-___ ___ ___ ___ ___-___ /___		**RCH UR number** *(If known to hospital)*	
Sex Assigned at Birth	**Gender**	**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**	
Indigenous status: ◯ **Aboriginal** ◯ **Torres Strait islander** ◯ **Not indigenous**			
Involvement of child protective services: ◯ **Yes** ◯ **No** **Worker contact details:**			
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

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Referral Agency Information

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

October 2022