Gender Diversity Service

Referral form

Disclaimer

Please complete this form with as much information as possible as this is essential for the referral to be progressed. This will help us know how best to respond. We welcome letters, assessment reports and any other relevant documentation in addition to this completed form. The Gender Diversity Service provides non-urgent assessment, information, support, and gender affirming care. GDS does not offer crisis response and cannot provide regular frequent psychological therapy. In the event of a mental health crisis please contact **CAMHS Crisis connect 1800 048 636** or present to an Emergency Department.

Referring agency information

Name	
Service	
Position	
Phone number	
Postal address	
Email address	
Date	

Complete this form and send to:
General Practitioners send to Central Referral Service via Secure messaging, fax or post. Other Health Professionals send to PCH Referrals. Please refer to PCH GDS website for details.

If completing digitally, please download and save this form before you start entering information

Please indicate the legal guardian who has provided consent for this referral to the Gender Diversity Service: _____

(If child is living independently as a mature minor, or is in the care of the Department of Communities, please indicate this)

Name of Parent 1:	Name of Parent 2:
Relationship to child:	Relationship to child:
Legal Guardian: Yes ☐	Legal Guardian: Yes ☐
No ☐	No ☐

Details of Child/Adolescent/young person being referred to the GDS:

1. Legal name: _____
2. Chosen name: _____
3. Pronouns: _____
4. Date of birth: ____/___/_____
5. Sex Registered at birth: _____
6. Ethnicity: _____
7. Primary language: _____ Other Languages: _____
8. Interpreter needed? Yes ☐ No ☐
9. Parent 1 name, phone number and residential address:

_____

_____

10. Parent 1 email address: _____

11. Parent 2 name, phone number and residential address:

_____

_____

12. Parent 2 email address: _____

13. Medicare number: ☐☐☐☐☐☐☐☐☐☐

Ref #: _____ Valid to: _____ Not eligible for Medicare? ☐

14. GP's name and address:

_____

_____

15. Does the parent consent to GDS contacting the GP?

Yes ☐ No ☐

Reason for referral and background of gender concerns, including duration of gender concerns. (e.g Age of awareness, family adjustment, name, pronouns, mental health, impact on functioning, wishes - what do the child/young person and family want from the service.

Is the patient socially transitioned?

Please give relevant medical history, including current medications,allergies:

Physical signs of puberty e.g. breast development, menarche, masculine hair development, voice changes

The following questions will assist us in understanding how we can best support the Child/Adolescent/young person being referred to the GDS, and work collaboratively with other service providers.

Is the patient seeing a mental health provider?

Yes ☐ No ☐

If yes, please provide name and contact details:

If no, has the GP provided a Mental Health Care Plan?

Yes ☐ No ☐

Mental health and development (e.g. Mood disorders, autism spectrum, ADHD, eating disorder):

Incidents of self-harm, suicide attempts or other risk concerns:

Family health and family mental health:

Involvement of other agencies or professionals (e.g. social services, CAMHS, voluntary sector, support group/s, private psychologist etc.)

The **Gender Diversity Service** is a specialist service which works collaboratively with other services as needed to meet the holistic needs of the child/adolescent/young person and families we see.

At the Gender Diversity Service, a young person and family may see a mental health nurse, psychiatrist, clinical psychologist, consultant endocrinologist, or another specialist at different times.

Due to a high demand for our service, we will contact you as soon as possible.