****

T-Clinic (Transgender Clinic)

*Providing Excellence in Multi-Disciplinary Care to Transgender and Gender Expansive Youth*

Main Office /Mailing Address Cornell Location

501 N Graham St Suite 375 1960 NW 167th Place Suite 103

Portland, OR 97227 Beaverton, OR 37227

(503) 413-1600 (ph.) 503-413-1915 (fax) 503-413-1600 (ph.) 503-413-1915 (fax)

Email: ChildrensEndocrineNurse@lhs.org

**T Clinic New Patient Intake Information Form**

(may write answers on back of page)

Legal Name

Preferred Name Preferred Pronouns

Date of Birth

Legal name change? (if yes, please bring paperwork to first visit for check in)

Gender Identity

Tell us a little bit about your child’s gender journey. When did they know? When did they tell you? (Or to the child: when did you know? When and how did you tell your parents? How did that go? ) Etc.

Has your child socially transitioned?  (Appears as and presents self (hair, clothes etc) as identified gender) All the time? At home only? Other conditions?

Please describe the child’s current living situation (custody if applicable, time spent at different houses etc.)

Please give us an idea of family members’ acceptance of patient’s gender identity.

How about their friends’ acceptance? Friends’ parents?

Is the child attending school?

Name of School : Grade:

Is the school aware of identified gender?

Has the school accepted identified gender?

Bathroom/locker room issues?

Enrolled with preferred name?

Bullying experience?

Learning challenges?

Please list any sources of support for

The child

The parents

Does your child have contact with other trans or gender non-conforming kids?  If so, is it a positive experience?

Medical History:

Does your child have any ongoing medical conditions we should know about?

Please list current medications taken on a regular basis

Mental Health History:

Is your child seeing a mental health provider currently?

Name of Provider

Length of time with this provider

To your knowledge, is your provider comfortable working with gender non-conforming youth?

Are they in agreement with you coming to T Clinic for medical intervention?

Does your child have any mental health diagnoses, such as anxiety, depression etc?

Please Explain:

Please list medications to treat these conditions if applicable.

Has your child been hospitalized for mental health concerns, such as suicidal ideation or attempt?

Please provide date(s) and short summary of experience.

Is there anything else about your child (Is there anything else you) would like us to know about?

What are your expectations of coming to T Clinic ?

Parent Expectations?

Child’s Expectations?

Please return completed form to

Connie Earnest-Ritchey, RN at the above listed main address, fax, or email

We are excited to learn about you!