**RCH Gender Care Center**

501 N. Graham St, Suite #375

Portland, OR 97227

503.413.1600

503.413.1915 (fax)

crobert@lhs.org (RN Email)

**Mental Health Questionnaire**

**for Gender Affirming Medical Care**

**Therapist Information:**

**Therapist Name:** Click here to enter text.

**Date:** Click here to enter text.

**Address:** Click here to enter text.

Click here to enter text.

**Email:** Click here to enter text.

**Phone:** Click here to enter text.

**Fax:** Click here to enter text.

**Best way, time to contact you:** Click here to enter text.

**Patient Information**

**Legal Name:** Click here to enter text. **Preferred Name:** Click here to enter text.

**Pronouns:** Click here to enter text.

**DOB:** Click here to enter text. **Age:** Click here to enter text.

**Sex assigned at Birth** Click here to enter text. **Gender Identity:** Click here to enter text.

**Length of Treatment:** Click here to enter text. **Visit Frequency:** Click here to enter text.

**Caregivers/guardians names and contact info**: Click here to enter text.

**Are caregivers/guardians supportive of this referral?** Click here to enter text.

**Have caregivers/guardians been involved in treatment so far?** Click here to enter text.

**Release of Info Signed**: Click here to enter text. **If yes, please attach.**

**Please describe this youth’s *gender journey* (when did they first start exploring gender, what supports and challenges have they had along the way?)**

Click here to enter text.

**Who are the youth’s *supports* in their gender transition? (family members, friends, community groups, faith community, school, other adults or professionals, etc.)**

Click here to enter text.

**What *cultural considerations* may be helpful for us to be aware of when working with this youth, including factors that may be *supportive* or *challenging* to gender transition? (religion, race, ethnicity, etc.)**

Click here to enter text.

**What do you see as this youth’s *strengths*?**

Click here to enter text.

**What are some *potential barriers* to care? (insurance coverage, lack of parental consent, transportation to appointments, uncertainty about what medical interventions they want, etc.)**

Click here to enter text.

**What *coping skills* and *resources* has the youth developed to address potential barriers?**

Click here to enter text.

**Does this youth meet the criteria for a diagnosis of gender dysphoria in DSM V?**

Click here to enter text.

**Has this youth been evaluated or diagnosed with *Autism Spectrum Disorder*? If so, please elaborate.**

Click here to enter text.

**Do you believe this youth would benefit from evaluation or resources around *Autism Spectrum Disorder*? If so, please elaborate.**

Click here to enter text.

**Please describe the patient’s *mental health history*, including how gender dysphoria may have impacted mental health. Please note if patient has had a *psychiatric hospitalization*, including when, and any pertinent information regarding hospitalization.**

Click here to enter text.

**Is this patient currently on any *mental health medications*? If so, please share medication, dose, length of time, efficacy, and prescriber.**

Click here to enter text.

**What gender affirming intervention(s) is this patient seeking? What benefits do you believe the patient would experience as a result of pursuing this care?**

Click here to enter text.

**Have the youth and parent(s)/guardian(s) been educated about potential risks and benefits of the medical intervention being sought? Please share what you have discussed with youth and parent(s)/guardian(s).**

Click here to enter text.

**Based on your assessment of client and family, do you believe that this gender affirming medical intervention is in the patient’s best interest at this time?**

Click here to enter text.

**What, if any, concerns do you have about this patient pursuing gender-affirming medical care?**

Click here to enter text.

**Please describe your treatment philosophy and your experience working with transgender and gender diverse youth. (relevant trainings, number of patients, number of years, etc.)**

Click here to enter text.

**We ask all mental health clinicians working with youth at our clinic to review WPATH standards of care (link below). Have you done this? Do you follow these standards? (https://wpath.org/publications/soc)**

Click here to enter text.

**What recommendations would you like to share for resources and supports as this patient seeks gender-affirming medical care (eg: ongoing individual therapy, consult for mental health medication, family therapy, peer support group, etc.)**

Click here to enter text.

**Is there anything else you would like us to know?**

Click here to enter text.

**Clinician Signature, Credential, License #, Date:**

**For Clinician’s that are working towards Licensure, Supervisor Signature, Credential, License #, Date:**

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**Thank you for your time. Please contact Clancy Roberts, LCSW at** **crobert@lhs.org** **or 503-413-5443 with any questions.**

**Please return to Randall Children’s Gender Care Center by either using a secure e-mail program to scan and e-mail to** **crobert@lhs.org****,** **fax to 503-413-1915 Attn: Clancy Roberts, or mail to Randall Children’s Gender Care Center, 501 N Graham, Suite 375 Portland, OR 97227**