

Mental Health Information:

**Therapist Name:** 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.

**Gender 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 patient’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 patient’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 patient, 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 patient’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 patient developed to address potential barriers?**

Click here to enter text.

**Does the patient meet the criteria for a diagnosis of gender dysphoria?**

Click here to enter text.

**Do you believe the patient 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 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.

**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.

**Have the patient and parents been educated about potential risks and benefits of the medical intervention being sought? Please share what you have discussed with patient.**

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.) Please note if you are a WPATH member or if you follow WPATH standards of care (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.

**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 T-Clinic 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 T-Clinic, 501 N Graham, Suite 375 Portland, OR 97227**