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 T-Clinic-PARENT/GUARDIAN

 *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: crobert@lhs.org

**T Clinic New Patient Intake Information Form**

(may write answers on back of page)

Date:

Your child’s Legal Name:

Your child’s Preferred Name: Your child’s pronouns:

Date of Birth:

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

Your name:

Best phone number to contact you:

Your child’s Gender Identity:

Tell us a little bit about your child’s gender journey. When did they know? When and how did did they tell you?

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 your 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 youth:

You, as parents/guardians:

Does your child have contact with other trans or gender diverse youth?  If so, can you tell us about that 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:

Contact Info:

Phone Number:

Length of time with this provider:

To your knowledge, is your provider comfortable working with gender diverse youth?

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

 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?

 Please return completed form to: (on back)

Check in Desk

 -or-

 if filling out remotely return to

Clancy Roberts, LCSW at

501 N Graham St Suite 375

Portland, OR 97227

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

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