Oregon Health & Science University Hospitals and Clinics

OC4501

REQUEST FOR TRANSGENDER HEALTH SERVICES

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

Fax this form and all pertinent medical records to THP at 503-346-6854

Medical Information

Primary diagnosis code

_____

_____

Is patient taking hormones

❑ Yes ❑ No

_____

_____

_____

_____

Patient's BMI

_____

Service you are requesting for your patient. <u>A service must be selected to process referral</u>

☐ Chest Surgery - Feminizing
☐ Chest Surgery - Masculinizing
☐ Facial Feminization Surgery
☐ Hair Removal (Electrolysis)
☐ Hair Removal (Laser)
☐ Gynecologic Care (Non-surgical)
☐ Gynecologic Care (Surgical)
☐ Obstetrics
☐ Metoidioplasty
☐ Orchiectomy
☐ Phalloplasty
  ☐ New
  ☐ Revision
❑ Vaginoplasty
  ☐ New
  ☐ Revision
❑ Other

_____

_____

Patient Demographics

Legal Name _____ Date of Birth _____/_____/_____

Affirmed Name _____ Pronoun _____

Other Names/Alias _____

Gender Identity _____

Sex assigned at birth ❑ Male ❑ Female ❑ Intersex ❑ Unknown

Mailing Address _____

City, State _____ Zip _____

Phone _____ Email _____

Insurance

Sex indicated on insurance ❑ Male ❑ Female

Name indicated on insurance _____

Plan Name _____ ID# _____

Prior authorization necessary ❑ Yes ❑ No

Self-Pay ❑

Interpreter

Interpreter needed? ❑ Yes ❑ No If yes, Language _____

Referring Provider Information

Name _____ Clinic _____

Role _____

City, State _____ E-mail _____

Phone No. _____ Fax _____

Office Contact _____

Primary Care Provider

PCP (if different from referring) _____

Phone _____ City, State _____