affirmclinic
10B Victoria Street S, Kitchener ON N2G 1C5
phone: 519-783-0022 | fax: 519-783-0032

The Centre for Family Medicine
Affirm Clinic Referral Form

Affirm Clinic Referral Form

- The Affirm Clinic is a welcoming gender-affirming consultative clinic with the aim to increase access to care in our community. Our goal is to support youth in their gender journey and increase access and capacity to healthcare in the region.
- The Affirm clinic is a consultation clinic only and care will be sent back to the primary care provider who must be agreeable to taking over the follow-up care. Affirm clinic will provide explicit instructions on appropriate follow-up.
- Patients can be re-referred back to the Affirm Clinic if they are interested in pursuing other treatment options or if there are further questions.

Referral Criteria Checklist:

Adolescent Gender Affirming Consultation (Must meet all criteria):

☐ Age 13-17 years of age
☐ Primary Care Provider aware of referral
☐ Primary Care Provider agreeable to take over the follow-up care
☐ No Complex developmental or complex mental health comorbidities *(Please refer directly to Dr. Linkletter if complex comorbidities)*

Has the patient been seen by the Affirm Clinic before? ☐ Yes ☐ No

Patient Demographic Information:

Patient's Legal Name (First & Last Name):____
Preferred Name *(if different from above)*: __________________ Pronouns: __________________
Date of Birth (DD/MM/YYYY): ___________________________ Age:_________________
Health Card Number: ___________________________________Version Code: ___________________
☐ Assigned Female at Birth (AFAB) ☐ Assigned Male at Birth (AMAB)
Address: ____
(Street, Unit, Town/City, Province, Postal Code)
Phone: ________________________________ Email: _________________________________

Consent to contact by telephone?	☐ Yes	☐ No
Consent to leave detailed voicemail?	☐ Yes	☐ No
Consent to email?	☐ Yes	☐ No
Consent to speak to others in the household?	☐ Yes	☐ No If yes, please specify (Name & Relationship): _______________________

Referring Provider Information:

Name: _________________________________
Address: ____
Telephone:_________________________________Fax: ________________________________
Billing Number *(if applicable)*: _____________________CPSO Number:_____________________

Primary Care Provider (if different from above):

Name: _________________________________
Address: ____
Telephone:_________________________________Fax:________________________________

Reason for Referral:

Diagnosis, Medical Transition (Medications), Surgical Transition, Other:

Comorbidities:

Medications:

Is the patient aware of this referral?	☐ Yes	☐ No
Is the Parent/Guardian aware of this referral?	☐ Yes	☐ No

Signature of Referring Provider: _________________________________ Date of Referral: _________________(DD/MM/YYYY)

Thank you for making a referral to the Affirm Clinic. Your involvement in this patient's care is important to us; if you have any questions or concerns, or wish to provide updated client information, please contact Admin at **519-783-0022** or **by fax 519-783-0032**

Updated: February 12, 2024