

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.		,	6 6	
Referral Criteria Checklist:				
Adolescent Gender Affirming Consultation (Mu	ıst meet all cri	teria):		
☐ 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? 🗆 Y	es 🗆 N	0	
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:				_
☐ Assigned Female at Birth (AFAB)	⊔ Assi	gned Mal	e at Birth (AMAB)	
Address:	/City Duayin	Dt.	I C - d - \	
(Street, Unit, Town/City, Province, Postal Code)				
Phone: Consent to contact by telephone?	Email:			
Consent to leave detailed voicemail?	☐ Yes	□ No		
Consent to email?	☐ Yes ☐ Yes	□ No □ No		
Consent to speak to others in the household?			If yes please specify (Name S	k Relationship):
Referring Provider Information:			ii yes, picase specify (Name e	k Kerationship).
Name:				
Address:				
Telephone:				_
Billing Number (if applicable):				
Primary Care Provider (if different from above		rtarriber		
Name:	•			
Address:				
Telephone:	Fax:			-
Reason for Referral:				
Diagnosis, Medical Transition (Medications), Surgical Transition, Other:				
Comorbidities:				
Comorbialities.				
Medications:				
IVICUICATIONS.				
Is the patient aware of this referral?	☐ Yes	□ No		
Is the Parent/Guardian aware of this referral?	☐ Yes	☐ No		
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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