UW MEDICINE Gender Affirmation Surgery Referral Request

Thank you for referring your patient to UW Medicine. This form is to be completed by the outside referring provider or designee along with the letter of support for the procedure requested. Per WPATH requirements, a separate referral and letter of support is required for each procedure requested. For information about making referrals to this program, go to https://depts.washington.edu/tgnbhealthprogram/gender-affirming-services/. A list of UW Medicine services, clinics, and providers can also be accessed on the same web page.

Fax this form to the UW Medicine Gender Affirmation department at 206-520-3104

Patient Information ----------

First & Last Name _____

Legal First & Last (if different) _____

Date of Birth _____ Pronoun(s) _____

Gender Identity _____

Sex Assigned at Birth: ☐ Male ☐ Female ☐ Intersex

Race _____ Ethnicity _____

Mailing Address _____

City, State _____ Zip _____

Phone (_____) _____ - _____ Email _____

Preferred Language _____

Insurance ----------

Insurance Company _____

Policy Plan Name _____

ID Number _____ Group _____

Referring Provider ----------

Referring Provider Name _____

NPI Number _____

Clinic Name _____

Clinic Address _____

City, State _____ Zip _____

Phone (_____) _____ - _____ Fax (_____) _____ - _____

Are you the patient's primary care or hormone replacement therapy (HRT) provider? ☐ Yes ☐ No

If no, list patient's PCP _____

Medical Information

Does the patient have a Gender Dysphoria (F64.0) diagnosis? ☐ Yes ☐ No

This is required for Gender Affirming surgery.

Is the patient taking hormones? ☐ Yes ☐ No

What surgical procedure is being requested?
*Note: A separate referral is needed for each procedure. Letters of support are required for procedures with an **

- ☐ Hysterectomy *
- ☐ Vaginectomy *
- ☐ Vulvovaginoplasty *
- ☐ Orchiectomy *
- ☐ Phalloplasty *
- ☐ Metoidioplasty *
- ☐ Breast Augmentation *
- ☐ Mastectomy *
- ☐ Facial Surgery *
- ☐ Voice Modification *
- ☐ Post-Operative Complication/Repair (no letter of support needed)

  Comments _____

  _____
- ☐ Other _____

  _____

  _____

PLACE PATIENT LABEL HERE

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