GENDER CLINIC REFERRAL FORM

Please email this completed form to: genderclinic@waac.com.au
For information about our Gender Affirming Care Clinic and referral process please go to: https://www.mclinic.org.au/service/gender-affirming-care/

Patient Referral to Dr. Joseph Cotter	**Today's Date:**
Patient Name and Contact Details	
First and Last Name:	
Name with Medicare (if different):	
Patient Mobile Phone:	Patient Home Phone:
Patient Email Address:	
Patient Address	
Street Name and #:	
City: State:	Post Code:
Pronouns:	Date of Birth (dd/mm/yyyy):
Gender: Male ☐ Female ☐ Non-binary ☐ Prefer not to say ☐	
Gender recorded at birth: Male ☐ F ☐ X ☐	
Reason for Referral	
Gender affirming care (GAC) with feminising hormone therapy: new ☐ ongoing ☐	
Gender affirming care (GAC) with masculinising hormone therapy: new ☐ ongoing ☐	
Brief history of gender incongruence or gender dysphoria	
Past GAC History (please attach any relevant supporting documents) Gender Diversity Service PCH ◯ WPATH Assessment ◯ Private specialist ◯ Gender Diversity Service RPH ◯ No previous GAC ◯	
Medical, mental health & surgical history (attach notes if necessary):	
Medications:	
Allergies:	
Referring GP Name:	**Provider Number:**
GP Clinic Name:	**GP Clinic Ph:**
GP Clinic St Name & #: **City:**	**Post Code:**