



GDAAY

GENDER DIVERSITY AND AFFIRMING ACTION FOR YOUTH

HEALTH PROVIDERS REFERRAL FORM

Please complete all sections and fax to GDAAY at 204-787-1655

PATIENT INFORMATION

Full name (as it appears on health card):

Date of Birth:

PHIN:

Chosen name:

Pronouns:

Tanner stage (*required):

Youth's home address:

Youth's phone number:

Is it safe for GDAAY to send correspondences to youth's address and leave a message at the indicated phone number? Yes No

- If assigned female at birth, has the youth started their period? If so, at what age?
- When did the youth begin to identify as their desired gender?
- Who in the youth's immediate family is safe/appropriate to contact?
- Is there anyone in the youth's immediate family that does not and/or cannot know about the youth's gender identity?

NAME OF REFERRING PHYSICIAN:

I am the youth's primary health-care provider: Yes No

Date received (office use only):