



Oregon Health & Science University
Hospitals and Clinics

OC-4501



REQUEST FOR TRANSGENDER
HEALTH SERVICES

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

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Patient Identification

Fax this form and all pertinent medical records to THP at 503-346-6854

Medical Information

Primary diagnosis code

- ☐ F64.9 Gender Incongruence
☐ Other _____

Patient's BMI _____

**Service you are requesting for
your patient. A service must
be selected to process referral**

- ☐ Voice Therapy
☐ Hair Removal
 ☐ Electrolysis)
 ☐ Laser
☐ Facial Surgery
☐ Tracheal Shave
☐ Voice Surgery
☐ Body Contouring
☐ Chest/Breast Surgery
☐ GYN Care/ Consultation/
 Surgery
☐ Metoidioplasty
☐ Phalloplasty
 ☐ New
 ☐ Revision
☐ Orchiectomy
☐ Vulvoplasty
☐ Vaginoplasty
 ☐ New
 ☐ Revision
☐ Hormone Consultation
 ☐ Initiation
 ☐ Continuation

☐ Other _____

Patient Demographics

Legal Name _____ Date of Birth ____/____/____

Affirmed Name _____ Pronoun _____

Other Names/Alias _____

Gender Identity _____

Sex assigned at birth ☐ Male ☐ Female ☐ Intersex ☐ Unknown

Mailing Address _____

City, State _____ Zip _____

Phone _____ Email _____

Insurance

Sex indicated on insurance ☐ Male ☐ Female

Name indicated on insurance _____

Plan Name _____ ID# _____

Interpreter

Interpreter needed? ☐ Yes ☐ No If yes, Language _____

Referring Provider Information:

Name _____ Clinic _____

Role _____

City, State _____ E-mail _____

Phone No. _____ Fax _____

Primary Care Provider

PCP (if different from referring) _____

Phone _____ City, State _____