



# GENDER CLINIC REFERRAL FORM

Please email this completed form to: [genderclinic@waac.com.au](mailto: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/>

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