TRANS CARE BC
Provincial Health Services Authority

March 2017

Caring for Trans and Gender Diverse Clients in BC:

A Primary Care Toolkit

Version 1.0

Contents

Acknowledgment of primary care working group

Trans Care BC would like to acknowledge the invaluable contributions of the Primary Care Working Group (PCWG) to the development of this toolkit. The PCWG brought together clinicians with extensive collective experience providing care to trans and gender diverse patients. Members came from diverse practice settings, rural and urban communities, and were cis and trans identified people. We thank them for sharing their knowledge and time and for their ongoing dedication to improving access to respectful and dignified health care for trans and gender diverse people.

Disclaimer

The PCWG was comprised of family physicians, nurse practitioners and nurses who have expertise in trans care by virtue of the volumes of patients they have seen and the care they have managed. This Primary Care toolkit has been developed not as a standard of care but rather as a general guide to assist clinicians who are or may be taking on similar work. The toolkit does not represent an exhaustive review of the medical literature, although many research articles and other protocols have been reviewed to inform the medical aspects of care.

Trans Care BC assumes no responsibility or liability for any harm, damage or other losses, direct or indirect, resulting from reliance on the use or the misuse of any information contained in this toolkit.

Introduction

Transgender people are an underserved population who continue to face societal stigma and discrimination in many areas including health care settings. They are disproportionately affected by poverty, homelessness, unemployment, and health problems such as depression, substance use disorders, and HIV. As primary care providers, nurse practitioners (NPs) and family physicians (GPs) are uniquely well positioned to address these health disparities and increase access to gender affirming health care. Historically, transgender care was provided in highly specialized gender clinics, but in the last decade there has been a shift toward distributed care models. In Canada and the US, there is increasing recognition that trans people can be well-served in primary care settings and that with some additional training family physicians and nurse practitioners can provide many aspects of gender affirming care. Trans people have the right to respectful, dignified, gender affirming health care in their home communities, and enhancing your skills and providing gender affirming care in your practice can have a profound impact on the health of trans people in your community.

Over the coming year, Trans Care BC will be developing comprehensive education modules and tools; in the interim this Primary Care Toolkit is intended to support GPs and NPs who are relatively new to providing care to trans people. It includes some basic information about gender-affirming treatment options and tools to assist with initiating and/or maintaining hormone therapy. It also directs you to further reading and provides suggestions for where you can access support from more experienced clinicians. This toolkit has been informed by the collective clinical expertise of the members of our Primary Care Working group and by existing guidelines from Canada and the US.

Gender affirming health care options

Gender affirming health care must be individualized according to a patient's goals and can involve many different aspects of social, medical, and surgical care. The care we provide is intended to relieve gender dysphoria. This has many benefits, including improved mental and physical health and improved social and occupational function.

> *Gender dysphoria refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) WPATH SOC v7*

Gender dysphoria may present at any age. Medical interventions, offered in a staged approach, may be appropriate for some individuals following the onset of puberty. Primary care providers may wish to work collaboratively with more advanced practice clinicians when caring for younger trans youth, especially when new to this area of practice. Please see the section on working with trans youth for more information about caring for younger patients.

Primary care providers have an important role to play in discussing gender identity and gender health goals with patients and providing treatment or referrals for treatment. The options outlined in this guide are appropriate for individuals with binary (identifying as male or female) and non-binary identities (identifying as a blend of male and female or identifying as neither male nor female), and individuals may require some, all, or none of these options.

Social options

Some trans people look to their primary care providers for support with non-medical and non-surgical aspects of gender affirmation. Some examples include assisting patients with name and identity changes (see transhealth.phsa.ca for more info), education about safer chest-binding or genital tucking, or counselling about common concerns such as coming out to friends and family or coping with transphobia.

Medical options

Medical care may involve the use of a progesterone-releasing IUD or medroxyprogesterone (Depo-Provera®) for suppression of monthly bleeding, leuprorelin (Lupron®) for puberty suppression, electrolysis for hair removal or hormone therapy.

Surgical options

Surgical care may include chest or breast surgery, gonadectomy, genital reconstruction, and a range of other procedures, including tracheal shave and facial surgery.

Role of the primary care provider:

- Provide an inclusive environment where patients will feel safe talking about their gender
- Respect your patient's right to self-determine their gender identity
- Maintain a gender affirming approach, including using chosen names and pronouns when interacting with, on behalf of, or when charting on your patient
- Be prepared to discuss gender dysphoria and the range of options available for addressing it
- Discuss current supports and plans for navigating transition in relationships, work or school settings and offer support and resources
- Assist patients to change their name and identification documents if desired (see transhealth.phsa.ca for more info)
- Work to stabilize any physical or mental health conditions to ensure they do not pose barriers to the patient accessing gender affirming interventions such as hormones or surgery
- For patients seeking hormone therapy:
    - Assess for readiness to begin hormone therapy or refer to someone who will
    - Initiate hormone therapy or refer to someone who will
    - Provide monitoring related to hormone therapy as needed
- For patients seeking surgical interventions:
    - Be familiar with the WPATH criteria for surgical intervention(s)
    - Complete a surgical readiness assessment if you are qualified, or refer to someone who can
    - Refer for surgery, provide post-op care and/or liaise with surgeons as needed

Help is available for primary care providers who would like to support a trans patient with gender affirming care but are unsure how to help – to access the Rapid Access to Consultative Expertise (RACE) Line, please call **604-696-2131** or toll free at **1-877-696-2131** and request the Transgender Health option.

Hormone readiness assessment

Primary care providers are well positioned to assess readiness for hormone therapy. While there is no waiting period required prior to initiating hormone therapy, there are a number of preparatory steps needed to ensure treatment is indicated and provided in the safest manner possible. Assessment by a psychologist or psychiatrist is not required for most people, however the primary care provider should assess both mental and physical health as part of care planning for starting hormones.

Assessment often takes place over a number of visits depending on the length of time available per visit, the clinical situation and the experience of the clinician. Please refer to Appendix A for sample questions that you can use to explore gender identity and gender affirming goals with your clients.

More visits may be required for clients with complex physical or mental health issues, or for clients who are socially isolated. Fewer visits may be appropriate for a straightforward patient, for more experienced clinicians, or if appointments are longer. Fewer visits may also be indicated in situations where harm reduction is the priority.

The purpose of these visits is to ensure your patient is ready from a medical and psychosocial perspective to begin hormone therapy. This is ideally done within a primary care setting using a gender-affirming, informed consent based approach. The checklist on the next page covers the important considerations and steps to take when getting ready to initiate hormone therapy.

Checklist for hormone readiness:

- [ ] Review gender identity and experience of gender dysphoria (see Appendix A)
- [ ] Discuss gender affirming goals
- [ ] Discuss hopes & expectations of hormone therapy
- [ ] General medical intake (complete medical history, family history etc.)
- [ ] Baseline blood work
- [ ] Physical exam (brief unless otherwise indicated: weight if patient agreeable, blood pressure, cardiovascular, respiratory & abdominal exams)
- [ ] Review of relevant health records
- [ ] Ensure the absence of absolute contraindications to hormone therapy
- [ ] Exclude differential diagnoses (e.g. delusional disorder mimicking gender dysphoria)
- [ ] Ensure patient has the capacity to consent for hormone therapy
- [ ] Discuss risk mitigation - e.g. counselling for smoking cessation
- [ ] Review effects of hormone therapy & ensure understanding of permanence
- [ ] Review potential side effects of hormone therapy
- [ ] Review potential risks of hormone therapy
- [ ] Review and sign consent form(s) (see Appendices B, C & D)
- [ ] Review recommendations for hormone monitoring and health screening
- [ ] Discuss fertility, contraception and sexual health
- [ ] Discuss support system(s), plans for work, school
- [ ] Refer for counselling or peer support (not a requirement but can be very beneficial)
- [ ] Discuss costs and apply for Special Authority to request coverage as appropriate

Overview of testosterone based hormone therapy

Medication	Dose instructions
Testosterone	
Testosterone cypionate 100mg/mL (injectable, suspended in cottonwood oil) **Testosterone enanthate 200mg/mL** (injectable, suspended in sesame oil)	Starting dose: 25 mg IM or SC q weekly Usual maintenance dose: 50-100 mg weekly If local skin reaction occurs, switch oils Weekly dosing is preferred to minimize peak/trough variation Biweekly injection (of 2x the weekly dose) may be tolerated in some individuals
Androderm® (patch)	Starting dose: 2.5 mg patch/24 h Usual maintenance dose: 5-10 mg/ 24h apply
Androgel® 1% (gel) 12.5 mg/pump or 25mg/2.5 mL sachet	Starting dose: 2 pumps daily Usual maintenance dose: 4-8 pumps daily (50-100 mg testosterone)
Axiron® 2% (axillary) 30mg/1.5 mL dose	Starting dose: 1 pump daily Usual maintenance dose: 2-3 pumps daily (60-90 mg testosterone)
Compounded testosterone (cream) 12.5 or 25 mg/0.2 mL Not covered but cheaper than other transdermal forms	Starting dose: 25 mg daily Usual maintenance dose: 50-100 mg daily
Progestins: May be used for contraception or to assist with menstrual suppression	
Medroxyprogesterone IM (Depo-Provera®)	150 mg IM q 12 weeks
Progesterone releasing IUD Higher dose progesterone preferred for suppression of menses	Insert by MD or NP. Devices effective for 3-5 years

It is important to review risks, benefits and potential side effects with patients prior to initiating treatment. Sample consent forms are included in this package – see Appendix B for the Testosterone Consent form.

Risk considerations: Contraindications to testosterone therapy may include unstable cardiovascular disease, pregnancy or chest/breast feeding, unstable psychosis or mania, active hormone-sensitive cancer and allergy. Many patients choose to begin or continue hormone therapy in spite of contraindications or higher risks. In such cases, care providers should do a careful informed consent process that takes into consideration the capacity of the patient to make an informed decision and the significant harm that can come from withholding treatment. Care providers may call the RACE Line at **604-696-2131** or toll free at **1-877-696-2131** and request the "Transgender Health" option to consult an experienced clinician.

Dose Titration: Titrate dose q 4-6 weeks until maintenance dose is achieved (e.g. 25 mg x 4-6 weeks, then 50 mg x 4-6 weeks, then 75 mg, etc.) A slower titration rate may be preferred by some patients or may be chosen based on clinical indication.

Goal of therapy: To maintain mid-injection cycle levels in the mid - high end of male range, minimize side effects and maintain expected rates of physical change (degree of change is influenced by patient preference).

Lab monitoring:

Request the lab to report male reference ranges

Baseline and q 6-12 months thereafter	• Testosterone, CBC, ALT, fasting glucose, and lipids, TSH
Following dose changes and 4-6 weeks after gonadectomy	• Mid-injection cycle testosterone, CBC, ALT • Trough testosterone if amenorrhea is delayed >6 months

Areas for review in follow up visits:

Subjective	Objective
■ Effects of hormones: physical, emotional ■ Current dose/desire for dose change ■ Side effects/concerns ■ Mental health: mood, body image, libido ■ Social: significant others, support, acceptance, safety, housing, finances ■ Lifestyle: exercise, nutrition, smoking, substance use	■ Blood pressure ■ Weight (baseline and q 6 months prn) ■ Mental status (brief assessment) ■ Cardiovascular and abdominal exam (baseline and yearly) ■ Labs ■ Other investigations as indicated

Managing side effects of testosterone, screening & health promotion

Managing side effects of testosterone	
Acne	Typically most problematic in the first year of hormone therapy Treat as per usual, consider lower dose or switching testosterone type if persistent
Scalp hair loss	Minoxidil – will not impact facial hair growth Finasteride – will inhibit facial hair growth
Polycythemia	Usually a misinterpretation due to lab using "female" ranges. Ensure the hemoglobin and hematocrit are being interpreted based on male laboratory ranges. If hemoglobin > 175 g/L or hematocrit > 0.52 or if symptomatic (headaches, facial flushing) increase frequency of dosing to weekly, reduce dose, or switch to a patch or gel to minimize peak/trough variation
Elevated transaminases	Usually transient unless another cause of hepatic dysfunction is identified
Unexpected (menstrual/cyclical) bleeding	Bleeding is typically suppressed within 6 months of starting testosterone. Evaluate for missed, inconsistent or excessive testosterone dosing (missed or inconsistent doses can cause spotting, excess testosterone can convert to estrogen with theoretical risk of endometrial proliferation) Check trough testosterone levels, estradiol, LH, FSH. Consider more frequent dosing (weekly at half the q 2 week dose) or dose adjustment. Persistent, unexplained bleeding should be evaluated with pelvic ultrasound +/- endometrial biopsy
Internal genital (vaginal) dryness	Check trough testosterone levels, estradiol, LH, FSH. If on a q 2 week injection cycle consider changing to q weekly injection (at half the q 2 week dose). May also consider dose adjustment. Estrace cream 0.5-1 g twice weekly or estradiol tablet 10 mcg twice weekly
Screening	
Cardiovascular risk	Testosterone increases cardiovascular risk factors but not overall morbidity or mortality. If using a risk calculator, use male scores if hormones were started early in life, female scores if hormones were started later (or both to estimate range)
Chest/Breast cancer	If client has not had chest surgery, screen as per BCCA guidelines The need for screening after chest surgery is controversial, however some breast tissue does remain after mastectomy. For high risk patient and/or patient concerns, examine chest wall and consider ultrasound to evaluate masses
Cervical cancer	Screen as per BCCA guidelines for patients with cervix and patients with hysterectomy On the requisition, use "T" for the gender marker, in the notes section indicate testosterone use, including dose and duration. See Appendix E - Sexual Health Screening
Sexual health	Some trans people may be at higher risk for sexually transmitted infections (STIs) including HIV and syphilis. Screen for STIs and consider HIV pre-exposure prohylaxis based on patient-specific risk factors. See Appendix E - Sexual Health Screening
Osteoporosis	No evidence of decreased bone density with testosterone use. Screen as per BCCA guidelines (65 and up) or earlier (50-64) if there have been long-term low levels of testosterone post oophorectomy. Elevated LH may be predictive of bone density loss. Encourage vitamin D and calcium intake and weight bearing exercise, maintain hormone therapy post-gonadectomy.
Colon cancer	As per guidelines

Overview of estrogen-based hormone therapy

Estrogen in combination with a testosterone blocking medication is used to reduce testosterone related features, induce estrogen related features and relieve gender dysphoria.

Medication	Dose
Androgen Blockers	
Spironolactone First line due to lower cost, effectiveness and tolerability May not significantly lower T levels alone	Starting dose: 50 mg po daily Usual maintenance dose: 200-300 mg daily. Can be divided bid
Cyproterone Eligible for Special Authority if needed to augment effect of primary anti-androgen	Starting dose: 25 mg po daily Usual maintenance dose: 25 – 100 mg daily
Finasteride May be added to the standard estrogen + androgen blocker regimen to reduce androgenic hair loss Not covered by Pharmacare	2.5 mg po every other day
Estrogen	
17-beta estradiol (Estrace®) Lowest risk of all estrogens and first choice	Starting dose 1-2 mg po daily Usual maintenance dose 4-8 mg daily Can be divided bid
Estradiol patch (Estradot®/Estraderm®) Eligible for Special Authority for clients >40 years old with additional risk factors	Starting dose 50 mcg patch twice per week. Usual maintenance dose 100-200 mcg twice weekly
Estradiol valerate (injectable) Only available compounded	Starting dose 10 mg IM q 2 weeks Usual maintenance dose 10-20 mg IM q 2 weeks
Progesterone	Not routinely recommended No clear evidence of benefit and likely increased risk Potential role in breast/nipple development (unproven)
Micronized progesterone (Prometrium®) First choice but more expensive	Starting dose 100 mg po daily Usual maintenance dose 100 – 400 mg daily
Medroxyprogesterone (Provera®)	Starting dose 5 mg po bid Usual maintenance dose 10-15 mg bid

It is important to review risks, benefits and potential side effects with patients prior to initiating treatment. Sample consent forms are included in this package- see Appendix C for Estrogen/Testosterone-blocker consent form and Appendix D for Progesterone consent form.

Risk considerations: Contraindications to estrogen therapy may include unstable cardiovascular disease, active hormone-sensitive cancer, end-stage liver disease and allergy. Many patients choose to begin or continue hormone therapy in spite of higher risks. In such cases, care providers should do a careful informed consent process that takes into consideration the capacity of the patient to make an informed decision and the significant harm that can come from withholding treatment. Care providers may call the RACE Line at **604-696-2131** or toll free at **1-877-696-2131** and request the "Transgender Health" option to consult an experienced clinician.

Dose Titration: Titrate dose of estrogen and androgen-blocker q 4-6 weeks until maintenance dose is achieved (e.g. 2 mg estrace + 50 mg spiro x 4-6 weeks, then 3 mg estrace + 100 mg spironolactone x 4-6 weeks, then 4 mg estrace + 150 mg spironolactone x 4-6 weeks, etc.) A slower titration rate may be preferred by some patients or may be chosen based on clinical indication.

Goal of therapy: To maintain testosterone levels in the female range, estrogen levels in the 300-800 mg range, minimize side effects and maintain expected rates of physical changes (degree of change influenced by patient preference).

Lab monitoring

Request the lab to report female reference ranges

Baseline and q 6-12 months thereafter	• Total testosterone, estradiol, CBC, ALT, fasting glucose, and lipids, electrolytes, TSH
Following dose changes and 4-6 weeks after gonadectomy	• Total testosterone, estradiol, ALT, electrolytes (if on spironolactone)

Areas for review in follow up visits

Subjective	Objective
■ Effects of hormones: physical, emotional ■ Current dose/desire for dose change ■ Side effects/concerns ■ Mental health: mood, body image, libido ■ Social: significant others, support, acceptance, safety, housing, finances ■ Lifestyle: exercise, nutrition, smoking, substance use	■ Blood pressure ■ Weight (baseline and q 6 months prn) ■ Mental status (brief assessment) ■ Cardiovascular and abdominal exam (baseline and yearly) ■ Labs ■ Other investigations as indicated

Managing side effects of estrogen, screening & health promotion

Managing side effects of Estrogen/Testosterone blockers and other common concerns	
Persistent dizziness/ postural hypotension	Caused by spironolactone, usually temporary and mild If severe or persistent switch to cyproterone. See Medication table for Special Authority eligibility
Low libido	Consider maintaining testosterone at higher level Trial of progesterone
Difficulty having/ maintaining erections	Consider maintaining testosterone at a higher level Trials of phosphodiaesterace Type 5 inhibitor (Cialis®, Viagra®)
Elevated prolactin	Common and typically benign with estrogen therapy. Some guidelines recommend routine measurement of prolactin while others do not Consider pituitary imaging if level is >80 mcg/L or if symptomatic (headaches, visual changes, excessive galactorrhea)
Elevated transaminases	Usually transient unless another cause of hepatic dysfunction identified
Increase in and/or malodorous vaginal discharge post-vaginoplasty	The lining of the vagina is created from inverted penile/scrotal skin (squamous epithelium) and oral antibiotics are therefore usually ineffective at treating bacterial overgrowth. Use intravaginal metronidazole gel bid and plain water douching until symptoms resolve See Appendix E - Sexual health screening for direction on how to assess vaginal symptoms post vaginoplasty
Screening	
Cardiovascular risk	Estrogen may increase cardiovascular risk. If using a risk calculator, use female scores if hormones were started early in life, male scores if hormones were started later (or both to estimate range) Consider daily ASA for higher risk patients
Breast cancer	Average risk factors, estrogen use >5 years & ages 65-71: q 2 years (ultrasound may be preferred modality) Higher risk factors (e.g. estrogen and progestin use > 5 years, positive family history, BMI > 35) & over age 50: screening mammography advisable
Osteoporosis	Screen as per usual guidelines (ages 65 and up) Screen earlier (ages 50-64) if there has been: • long-term low levels of estrogen post gonadectomy, or • long-term use of androgen blocker without estrogen Encourage vitamin D and calcium intake and exercise, maintain hormone therapy post-gonadectomy
Colon cancer	Screen as per BCCA guidelines
Prostate cancer	Long term androgen suppression likely lowers the risk of prostate cancer but providers may choose to screen as per BCCA guidelines. PSA may be less reliable/falsely elevated in low androgen settings. If indicated, assess the prostate with a vaginal exam (located anterior to the vagina)
Sexual health	Some trans people may be at higher risk for sexually transmitted infections (STIs) including HIV and syphilis. Screen for STIs and consider HIV pre-exposure prohylaxis based on patient-specific risk factors. See Appendix E - Sexual health screening

Surgical readiness assessment

Some trans and gender diverse people benefit from gender affirming surgery. Eligibility is based on the patient meeting WPATH criteria for the specific surgery and psychosocial readiness. To access publicly funded surgery, one or two assessments by qualified providers are required (the number of assessments depends on type of surgery). In private pay situations, surgeons set their own criteria regarding what type of assessment is required and by whom. Primary care providers may receive training and a period of clinical supervision to become qualified to provide these assessments. If you are not currently a qualified surgical assessor but are interested in becoming one, or if you require assistance with the completion of an assessment(s) for your patient, please contact the Trans Care BC Care Coordination team at at **1-866-999-1514**. See Appendix G for a description of TCBC Care Coordination team and Appendix H for the referral form to the team.

Once the required assessments are complete you can refer your patient for surgery. Please see Appendix F for a summary of surgical referral options and documentation requirements for each surgery.

WPATH criteria*	Upper body (Chest/breast)	Gonadectomy	Genital construction
Persistent, well-documented gender dysphoria	✓	✓	✓
Capacity to make a fully informed decision and to consent for treatment	✓	✓	✓
Age of majority in a given country	✓	✓	✓
If significant medical or mental health concerns are present, they must be reasonably well-controlled for upper body surgeries, and well controlled for gonadectomy and genital surgeries	✓	✓	✓
One year of hormone therapy unless contraindicated or not consistent with gender goals		✓	✓
One year of living congruently with gender identity			✓

* Note that these are only guidelines and clinicians should continue to apply clinical judgment. Surgery, especially upper body surgeries, may be appropriate for those under the age of the majority who have the capacity to consent as defined by the BC Infants Act. Please see the section on working with trans youth for further discussion.

Overview of gender affirming surgeries

Type of care	Description/purpose	Coverage	Assessments required	Location
Breast construction	Implantation of prosthesis to enhance size of breasts	Public but only under special circumstances[a]	One	BC Any plastic surgeon
Subcutaneous mastectomy & chest contouring	Removal of breast tissue and creation of a flatter and/or more sculpted chest	Public	One	BC Centralized wait list
Hysterectomy with bilateral salpingo-oophorectomy	Removal of uterus, ovaries, and fallopian tubes May eliminate the need for pap tests. Eliminates risk of ovarian, uterine, and cervical cancer. Prevents monthly bleeding	Public	Variable	BC Any gynecologist
Orchiectomy	Removal of testes Eliminates need for testosterone blocker	Public	Variable	BC Any urologist
Vaginoplasty	Creation of vagina and vulva (including mons, labia, clitoris, and urethral opening) and removal of penis, scrotum, and testes	Public	Two	Montreal
Vulvoplasty	Creation of vulva (including mons, labia, clitoris, and urethral opening) and removal of penis, scrotum, and testes	Public	Two	Montreal
Clitoral release	Ligaments around clitoris are cut releasing clitoris from the pubis and allowing creation of penis 4-6cm long	Public	Two	Montreal or out of country[b]

Type of care	Description/purpose	Coverage	Assessments required	Location
Metoidioplasty	Clitoral release plus urethral lengthening and incorporation into penis, increased girth of penis using skin from labia Creation of scrotum from labia, +/- vaginectomy and scrotal implants	Public	Two	Montreal or out of country[b]
Phalloplasty	3 phase surgery to create penis, scrotal sac, and testes using genital and tissue grafted from forearm, thigh or back	Public	Two	Montreal or out of country[b]
Facial surgery	May include alterations to the facial bones, cheeks, forehead, nose, hairline and areas surrounding the eyes, ears, or lips	Private	Variable	BC
Tracheal shave	Reduction and reshaping of thyroid cartilage	Private	Variable	BC
Voice surgery	Alteration of vocal fold mass and/or tension to elevate pitch	Private	Variable	Toronto or out of country
Liposuction or lipofilling	Removal or transfer of body fat to achieve desired body contour	Private	Variable	BC
Pectoral augmentation	Implants placed beneath pectoral muscles to increase size and projection of muscles	Private	Variable	BC

[a] If < AA cup or > 1.5 cup size asymmetry breast growth after 18 months of feminizing hormone therapy (unless contraindicated}

[b] For consideration of publicly funded out of country surgery, contact Trans Care BC

Working with trans youth

Considerations when working with youth

Primary care providers have an important role to play in caring for trans youth. We can provide education and counselling to trans youth and families, link them with resources, and assist them to access gender affirming medical and surgical treatments.

Receiving gender affirming care can have significant health benefits for trans youth. The decisions to initiate medical treatment may be straightforward or more complex depending on age, level of independence, level of family support, and the presence of physical and/or mental health concerns. Care providers may choose to involve other professionals in assessment and/or treatment, especially in situations that are more complex. Outlined on the next page is an algorithm that may assist in decision making related to whether a specialist referral might be needed.

Family support is highly protective for trans youth. Care providers should therefore seek to nurture and sustain supportive relationships between trans youth and their families. Ideally, decisions regarding medical treatment are made collaboratively between the care provider, the youth and their family. However, there are times when parental involvement may not be desired or parental support may not be forthcoming. In these situations, the risks and benefits of providing treatment in the absence of parental support must be weighed against the risks and benefits of withholding treatment. Within the province of BC, the Infants Act allows clinicians to provide treatment to competent minors in the absence of parental consent.

Infants act

Medical treatment of youth in British Columbia is governed by the Infants Act. Medical treatment for minors (defined in provincial legislation as a person under the age of 19) can be provided in the absence of parental consent if (a) the health provider has explained the treatment options to the youth and is satisfied that the youth "understands the nature and consequences and the reasonably foreseeable benefits and risks"; (b) the health provider has made "reasonable efforts to determine and has concluded that the health care is in the infant's best interests," and (c) the youth has provided consent.

Therefore, youth who are legally competent to consent to medical treatment that is in their best interest may do so without the consent of their parent or guardian.

Medical interventions for trans youth

Medical interventions differ depending on the age and stage of development when a youth presents for care. Youth in the early stages of puberty may benefit from a period of puberty suppression followed by initiation of hormone therapy at a later age, whereas those who present in the later stages of puberty may proceed directly to hormone therapy. Research has shown that trans youth who have access to puberty suppression, hormone therapy and gender affirming surgery do as well, or better, in in terms of psychosocial functioning compared to non-trans peers.

A readiness assessment needs to be done prior to initiating medical therapy and should include all elements described previously, an assessment of capacity as needed and additional assessments depending on the age and developmental stage of the youth and their social situation. In addition, care providers must be prepared to work with families, educators and others involved in the youth's life, as needed, to ensure the youth has the social support needed for a successful transition. As with adults, assessment can be done by a range of professionals including advanced practice NPs and GPs who have received training related to working with youth. If you would like information about care providers in your area who have experience working with trans youth or if you would like to receive further training in working with trans youth please contact Trans Care BC at **1-866-999-1514**. See Appendices G & H for more information on the Trans Care BC Care Coordination Team and a referral form.

Puberty-suppression

Youth in the early stages of puberty may benefit from a period of puberty suppression using leuprorelin (Lupron®) which is a GnRH analog. Leuprorelin is a safe treatment that blocks unwanted and distressing pubertal changes while allowing time for the youth to mature and for the youth and family to carefully consider decisions about further medical intervention.

Hormone therapy

Trans youth who are either past puberty or for whom puberty is well-advanced may benefit from hormone therapy. Initiation of hormone therapy can be considered for youth whether they have had a period of puberty suppression or not.

Surgery

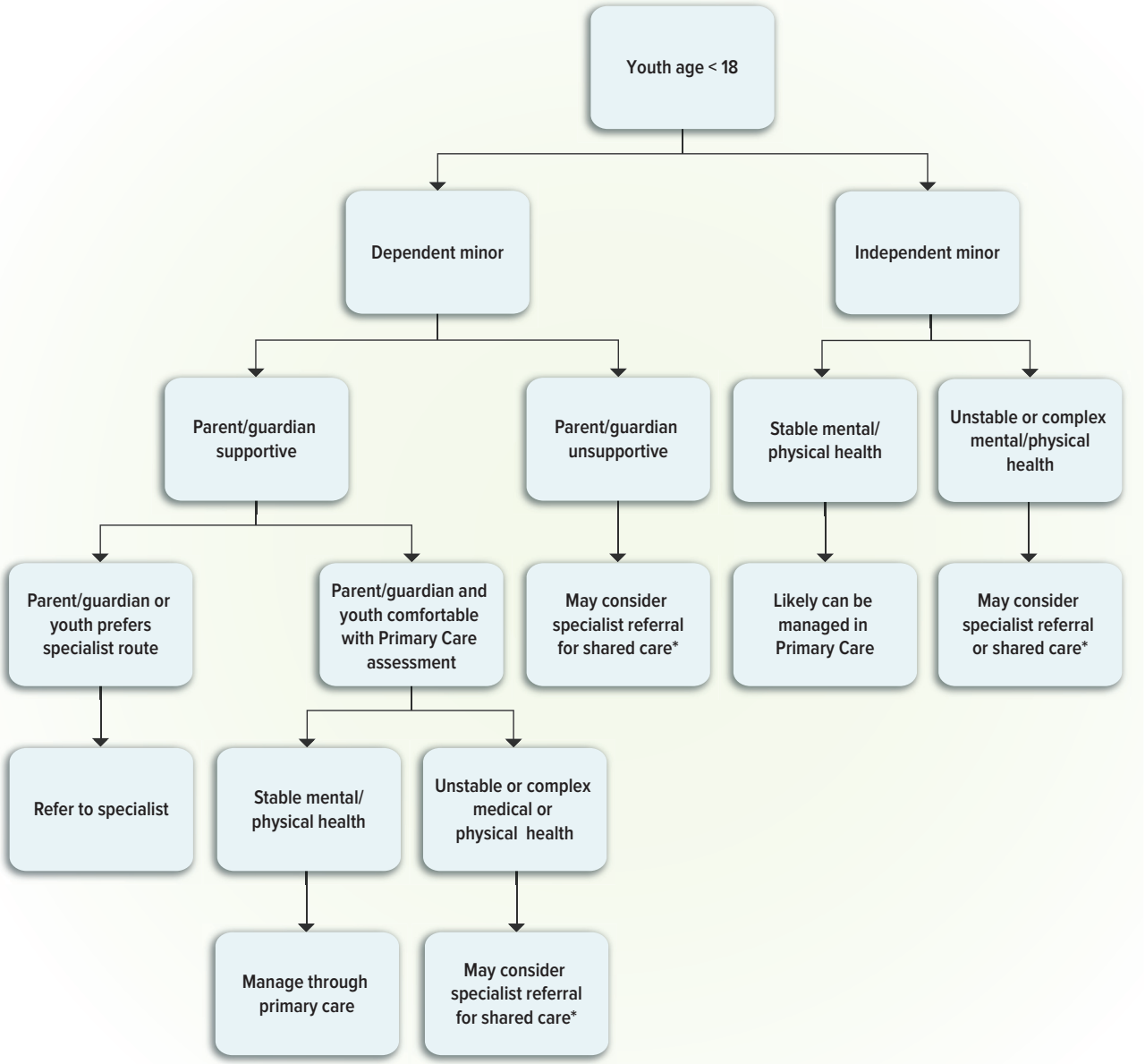
Upper body surgeries may be appropriate for many youth under the age of the majority.

Gonadectomy and genital surgeries are usually only done for youth 18 and older, although there may be rare exceptions for those who began their transitions at a young age.

As with adults, assessment by qualified surgical assessors is required and some surgeons may request additional assessments, depending on the age of the youth.

Algorithm to support decision making regarding medical interventions and youth

Depending on clinician experience, specialist referral for consultation or shared care may be beneficial under any circumstance. The algorithm below can help guide decision-making related to specialist referral.



* Specialist referral may be indicated as part of assessment and care planning (consultation only) or as an alternative route for assessment and care planning, treatment initiation and ongoing monitoring. Things to consider: age and competency of the youth, youth's willingness to include parents/guardians in care planning, availability of specialists, ability to pay for private specialists (e.g., psychology), potential harms of delaying treatment, likelihood that family support and education from the primary care provider will impact parent/guardian support for treatment.

Additional resources & references

1. The Trans Care BC website (transhealth.phsa.ca) provides a broad spectrum of information for health professionals, trans and gender diverse youth, adults and families. Some of the resources include:

Social	Trans 101 ID and name change Hair removal	Coming out Changing speech Binding, packing and tucking
Support	Support groups Information for immigrants and refugees	Information for children and families Information on mental health resources
Providers	Guideline documents and standards Copies of consent forms Clinical mentorship call (for GPs and NPs new to providing gender affirming care)	Copies of surgical referral forms Information on the application process for out of country surgeries

2. Trans Care BC Care Coordination Team: **1-866-999-1514** or transcareteam@phsa.ca
3. Rapid Access to Consultative Expertise (RACE) Line: **604-696-2131** or **1-877-696-2131** and select the "Transgender Health" option
4. BC Endocrine standards: transhealth.phsa.ca/wp-content/uploads/sites/15/2014/05/BC_Trans_Adult_Endocrine_Guidelines_2015.Ver1_.1.pdf
5. WPATH Standards version 7: www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=3926
6. Sherbourne Hormone Therapy Guidelines: sherbourne.on.ca/wp-content/uploads/2014/02/Guidelines-and-Protocols-for-Comprehensive-Primary-Care-for-Trans-Clients-2015.pdf
7. Rainbow Health: www.rainbowhealthontario.ca/TransHealthGuide/
8. Guidelines for the Primary and Gender – Affirming Care of Transgender and Gender Non-binary People, UCSF: transhealth.ucsf.edu/protocols
9. Canadian Professional Association for Transgender Health: www.cpath.ca
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Appendix A

Asking about gender identity and gender affirming goals

Sample questions for patients seeking hormone therapy

There are many ways to inquire about gender identity and expression and to discuss what to expect from hormone therapy. Below are some sample questions that can guide the discussion.

These questions are suggestions meant to benefit those who are new to this work. Please feel free to adapt them to your own style. It is important to remember that there is no one way that trans people experience gender dysphoria. Some people feel dysphoric about certain aspects of their bodies and other people feel discomfort with the gender role associated with their assigned sex. Dysphoria and a desire for gender affirming medical or surgical intervention can emerge at any age. Staying open to your patient's unique experience and goals is the best way to provide gender affirming care.

Sample questions:

1. How would you describe your gender identity? If prompting is needed: For example, some people identify as a man, a trans man, genderqueer, etc.
2. Do you remember the time when you realized that your gender was different from the one you were assigned at birth? Or: Do you remember when you first started to see your gender as _____?
3. Can you tell me a bit about what's happened since realizing this? If prompting is needed: Some people find this to be a difficult realization and may not feel safe to discuss it, other people are fortunate to have people in their life they feel safe talking with – what was it like for you?
4. Have you taken any steps to express your gender differently/to feel more comfortable in your gender? If prompting is needed: Some people ask others to use a different name and pronoun, or make changes to their hair or clothing styles.
5. If they have taken steps to express their gender differently: What was that like for you? How did that feel?
6. Are you hoping to take any other steps in the future?
7. Have you thought about how you will manage the changes in your appearance and gender expression at work or school?
8. Who has supported you along the way? If they have not spoken with anyone else yet: Who do you think might be supportive if you bring this up with them?
9. When did you start thinking about taking hormone therapy?
10. What do you anticipate to be the main benefits of hormone therapy?
11. What changes from hormones are you most looking forward to?
12. Are there any potential changes that you are not sure of?
13. Have you done anything to prepare yourself for this step? If prompting is needed: Have you talked with any peers, or asked friends or family for support? Done any reading or research?
14. Do you anticipate any challenges?
15. Who is there to support you with any challenges that do occur?
16. Are you aware of some of the risks related to hormone therapy?
17. Do you know about the potential impact that taking hormones can have on your fertility? Would you like me to refer you to a fertility clinic to talk about fertility preservation options?
18. Some people find it helpful to have the support of a counsellor for either decision making or ongoing support after beginning hormone therapy – would you like a referral to a trans competent counsellor?
19. Do you have any questions for me?

Appendix B

Testosterone consent

Testosterone consent

Testosterone is used to reduce estrogen-related features and induce testosterone-related features in order to make you feel more at ease in your body.

Informed consent is used to make sure you know what to expect from hormone therapy including physical and emotional changes, side effects and potential risks. The full medical effects and safety are not fully known and some potential risks are serious and possibly fatal. These risks must be weighed against the benefits that hormone therapy can have on your health and quality of life. Benefits may include increased comfort in your body, decreased dysphoria, improved mental health and increased success in work, school and relationships. Each person responds differently to hormone therapy and the amount of change varies from person to person. Testosterone is available in several forms but most people use injectable testosterone due to lower cost.

Testosterone-related effects

Testosterone related changes may include:	Expected onset	Expected maximum effect
*Deeper voice	3-12 months	Years
*Growth of body and facial hair	3-6 months	3-5 years
*Growth of the external genitals (clitoris)	3-6 months	1-2 years
*Scalp hair loss	>12 months	Variable
Decreased fertility	Variable	Variable
Fat redistribution and possible weight gain or loss	3-6 months	2-5 years
Increased muscle	6-12 months	2-5 years
Mood changes	Variable	Variable
Changes to sex drive, sexual interests or sexual function	Variable	Variable
Skin changes including increased oil and acne	1-6 months	1-2 years
Dryness of internal genitals (vagina)	3-6 months	1-2 years
Stopping of monthly bleeding (period)	2-6 months	n/a

From the World Professional Assocation of Transgender Health's Standards of Care, Version 7

*Change is permanent and will remain even if hormone therapy is stopped

Potential Risks	
Increased red blood cells (polycythemia) **Sleep apnea** **Scalp hair loss (balding)**	Likely increased risk
Changes to cholesterol which may increase risk for heart attack or stroke **Liver inflammation**	Possible increased risk
Diabetes **Heart and circulation problems (cardiovascular disease)** **Increased blood pressure**	Possible increased risk if you have additional risk factors

Risks for some of these conditions may be affected by:

- Pre-existing physical or mental health conditions
- Family history of physical or mental health conditions
- Cigarette smoking or other substance use
- Nutrition, exercise, stress

_____ (name of care provider) has discussed with me the nature and purpose of hormone therapy; the benefits and risks, including the possibility that hormone therapy may not accomplish the changes I want; the possible or likely consequences of hormone therapy; and other alternative diagnostic or treatment options

1. I have read and understand the above information regarding hormone therapy, and accept the risks involved
2. I have had enough opportunity to discuss my my health, goals and treatment options with my care provider, and all of my questions have been answered to my satisfaction
3. I believe I have adequate knowledge on which to base informed consent to receive hormone therapy
4. I authorize and give my informed consent to receive hormone therapy

Patient signature _____ Provider signature _____

Date _____

Appendix C

Estrogen/Testosterone-blocker consent

Estrogen/Testosterone-blocker consent

Estrogen and testosterone-blockers are used to reduce testosterone-related features and induce estrogen-related features in order to help you to feel more at ease in your body.

Informed consent is used to make sure you know what to expect from hormone therapy including physical and emotional changes, side effects and potential risks. The full medical effects and safety are not fully known and some potential risks are serious and possibly fatal. These risks must be weighed against the benefits that hormone therapy can have on your health and quality of life. Benefits may include increased comfort in your body, decreased dysphoria, improved mental health and increased success in work, school and relationships. Each person responds differently to hormone therapy and the amount of change varies from person to person.

Estrogen is available in several forms. Most people use pills due to lower cost but transdermal forms may lower the cardiovascular risks associated with estrogen.

Estrogen/testosterone blockers related changes may include:	Expected onset	Expected Maximum effect
* Breast growth	3-6 months	2-3 years
* Smaller genitals (testes)	3-6 months	2-3 years
Decreased fertility	Variable	Variable
Fat redistribution and potentially weight gain or loss	3-6 months	2-5 years
Decreased muscle mass	3-6 months	1-2 years
Mood changes	Variable	Variable
Decreased spontaneous genital arousal (erections)	1-3 months	3-6 months
Changes to sex drive, sexual interests or sexual function	Variable	Variable
Skin changes including softening & decreased oiliness	1-6 months	Unknown
Decreased growth of body & facial hair	6-12 months	3 years
Decreased scalp hair loss (balding)	No regrowth, loss stops 1-3 months	1-2 years

From the World Professional Assocation of Transgender Health's Standards of Care, Version 7

*Change is permanent and will remain even if hormone therapy is stopped

Potential Risks	
Increased risk of blood clots, pulmonary embolism (blood clot in the lung), stroke or heart attack **Gall stones**	Likely increased risk
Changes to cholesterol which may increase risk for pancreatitis, heart attack or stroke **Liver inflammation** **Nausea** **Headaches**	Possible increased risk
Diabetes **Heart and circulation problems (cardiovascular disease)** **Changes to kidney function (if using spironolactone)** **Increased potassium which can lead to heart arrhythmias (irregular heart beat) if using spironolactone** **Increased blood pressure** **Breast cancer** **Increased prolactin and possibility of benign pituitary tumours**	Possible increased risk if you have additional risk factors

Risks for some of these conditions may be affected by:

- Pre-existing physical or mental health conditions
- Family history of physical or mental health conditions
- Cigarette smoking or other substance use
- Nutrition, exercise, stress

_____ (name of care provider) has discussed with me the nature and purpose of hormone therapy; the benefits and risks, including the possibilty that hormone therapy may not accomplish the changes I want; the possible or likely consequences of hormone therapy; and other alternative diagnostic or treatment options

1. I have read and understand the above information regarding hormone therapy, and accept the risks involved
2. I have had enough opportunity to discuss my health, goals and treatment options with my care provider, and all of my questions have been answered to my satisfaction
3. I believe I have adequate knowledge on which to base informed consent to receive hormone therapy
4. I authorize and give my informed consent to receive hormone therapy

Patient signature _____ Provider signature _____

Date _____

Appendix D

Progesterone consent

Progesterone consent

Progesterone is not included in standard hormone regimens but may be desired by some trans people. Requests for progesterone are usually related to a desire to enhance breast development. While there is no clear evidence of benefit from progesterone, some trans people and clinicians believe that it may have a role in breast and areola/nipple development and/or may be beneficial for enhancing sex drive, sleep and mood.

Research suggests that taking a combination of both estrogen and progesterone carries higher risk for cardiovascular disease and breast cancer compared to taking estrogen on its own. This research came from a study of older cisgender (non-trans) women going through menopause who were using a type of estrogen that is no longer recommended. Because there is evidence showing increased risk associated with progesterone use and a lack of clear evidence showing benefits, progesterone is not generally recommended in published gender-affirming care guidelines. However, some experts believe that this evidence does not apply to trans people taking hormone therapy.

This means that some care providers may decide to include progesterone, at least for a trial period, after a careful discussion of risks and benefits. They may request that patients sign an additional consent form if progesterone is prescribed.

Additional risks from progesterone may include:	
Heart and circulation problems (cardiovascular disease)	Diabetes
Breast cancer	Testosterone-like effects such as increased body hair, acne
Mood changes including depression	Weight gain
Increased blood pressure and cholesterol	

Risks for some of these conditions may be affected by:

- Pre-existing physical or mental health conditions
- Family history of physical or mental health conditions
- Cigarette smoking or other substance use
- Nutrition, exercise, stress

_____ (name of care provider) has discussed with me the nature and purpose of hormone therapy; the benefits and risks, including the possibility that hormone therapy may not accomplish the changes I want; the possible or likely consequences of hormone therapy; and other alternative diagnostic or treatment options

1. I have read and understand the above information regarding hormone therapy, and accept the risks involved
2. I have had enough opportunity to discuss my health, goals and treatment options with my care provider, and all of my questions have been answered to my satisfaction
3. I believe I have adequate knowledge on which to base informed consent to receive hormone therapy
4. I authorize and give my informed consent to receive hormone therapy

Patient signature _____ Provider signature _____

Date _____

Appendix E

Sexual health screening

Sexual health screening

All patients should be screened according to the types of sexual activities they participate in, including screening throats, rectums, genitals and genital lesions as indicated. Serology should be included during routine STI screening for all patients, including TP EIA, HIV, and Hepatitis A, B & C as indicated. Assess need for immunizations (HPV, HAV, HBV) and HIV PrEP on an individual basis. Self-swabbing, blind swabs and urine CT/GC NAATs are appropriate for symptomatic patients who do not desire a physical exam. BCCDC's GetCheckedOnline.com is an excellent screening option for asymptomatic clients as well.

Site	Asymptomatic	Symptomatic	Notes
Penile urethra (with or without phalloplasty or metoidioplasty with urethral lengthening)	• Urine CT/GC NAT	• 1st: GC C&S (mini-tip amies gel swab with soft aluminum wire, green top) • 2nd: HSV NAT (if tolerable) • 3rd: Urine CT/GC NAT	If discharge is present, attempt to collect exudate by having patient milk shaft to avoid further irritation of the urethra
Vagina after vaginoplasty If pain, discharge or bleeding occur in the early post-operative period, consult with an experienced clinician: RACE line: 604-696-2131 or toll-free at 1-877-696-2131 and request the "Transgender Health" option Trans Care BC: 1-866-999-1514 transcareteam@phsa.ca	• Urine CT/GC NAT Some women may find pelvic exams affirming. If patient preference is for pelvic exam: -Clinician collected vaginal CT/GC NAT (orange Gen-Probe Aptima vaginal swab). Note that is has not been validated for use in vaginoplasty • There is no evidence to support the need for Pap tests of vaginal vault	• Urine CT/GC NAT	Order of collection is not important
		• Trich NAT (use same Urine NAT or same orange Gen-Probe Aptima vaginal swab as for CT/GC). Note that is has not been validated for use in vaginoplasty	• Collected on same swab as the CT/GC. Request Trich NAT on BCCDC Bacteriology & Mycology requisition. Must be sent to BCCDC
		• Comprehensive yeast & bacterial culture (liquid Amies culture red-top swab)	• Must be sent to Life Labs. On LifeLabs requisition, under "Routine Culture", indicate "Other: Genital wound culture"
		• Prostate exam prn (Note: the prostate is not removed during vaginoplasty)	• Assessment can be done by digital exam via lower aspect of anterior vaginal wall

Site	Asymptomatic	Symptomatic	Notes
Vagina after total hysterectomy See BCCDC's Pelvic Exam Decision Support Tool (March 2017)	• Urine CT/GC NAT or • Patient collected vaginal CT/GC NAT (orange vaginal Gen-Probe Aptima swab)	• Vaginal CT/GC NAT (orange Gen-Probe Aptima swab)	Order of collection not important
		• Trich NAT	• Collected on same swab as the CT/GC. Request Trich NAT on BCCDC Bacteriology & Mycology requisition. Must be sent to BCCDC
		• Culture or vaginal smear for BV & yeast	
	• See "BCCA Screening for Cancer of the Cervix" (June 2016) to determine screening recommendations for patients with removal of cervix		
Vagina with cervix See BCCDC's Pelvic Exam Decision Support Tool (March 2017)	• Urine CT/GC NAT or • Patient collected vaginal CT/GC NAT (orange vaginal Gen-Probe Aptima swab)	• Vaginal CT/GC NAT (orange Gen-Probe Aptima swab)	Order of collection is not important
		• Trich NAT	• Collected on same swab as the CT/GC. Request Trich NAT on BCCDC Bacteriology & Mycology requisition. Must be sent to BCCDC
		• Culture or vaginal smear for BV & yeast	
		• Bi-manual exam. If patient is not able to tolerate bi-manual, assess for fundal tenderness only	• Note that patients on testosterone may have cervical motion tenderness (CMT) due to atrophy (presence of CMT not necessarily indicative of Pelvic Inflammatory Disease)
	• Cervical screening prn	• If due for cervical screening, advise patient that inflammatory exudate may obscure endo-cervical cells, and recommend booking a separate appointment for cervical screening	

Appendix F

Referring a patient for gender affirming surgery

Referring a patient for gender affirming surgery

If you have referred your patient for surgical readiness assessment(s), the completed recommendation form(s) will be returned to you, and you will then make the surgical referral as follows:

Chest surgery

- Surgeries are done in British Columbia by plastic surgeons trained to perform mastectomy plus chest contouring. Referrals for chest surgery should be faxed to Dr Cameron Bowman: **604-734-1404**
- Your patient will be placed on a centralized list and will be contacted as to their surgeon of choice.

Breast surgery

- Surgeries are done in British Columbia by any plastic surgeon trained to perform breast construction, but are only available under special circumstances (less than AA cup breast development or > 1.5 cup size asymmetry after at least 18 months on hormone therapy). The surgeon will assess the patient and complete the funding application if indicated. Please refer your patient to the surgeon of your choice or contact the RACE Line for information on surgeons providing gender affirming care.

Hysterectomy & bilateral salpingo-oophorectomy

- In British Columbia these procedures are done by any gynecologist. Please refer your patient to the surgeon of your choice or contact the RACE Line for information on surgeons providing gender affirming care: **604-696-2131** or toll-free **1-877-696-2131**.

Orchiectomy

- This is done concurrently with vaginoplasty/vulvoplasty. When this procedure is done alone, any urologist in British Columbia can do the surgery. Please refer your patient to the surgeon of your choice or contact the RACE Line for information on surgeons providing gender affirming care: **604-696-2131** or toll-free **1-877-696-2131**.

Vaginoplasty or simple vulvoplasty (includes orchiectomy if not done previously)

- These surgeries are done in Montreal at GRS Montreal: www.grsmontreal.com
- Please refer your patient to Drs. Belanger, Bensimon and Brassard by faxing the information to **1-514-288-3547**.
- Once the referral has been made, ask your patient to contact GRS Montreal to initiate their surgical booking: **1-514-288-2097** or info@grsmontreal.com

Phalloplasty, metoidioplasty and clitoral release

- These procedures are generally done in Montreal at the GRS Montreal Clinic but clients are able to submit an out of country application for consideration.
- To refer a patients to GRS Montreal please fax the information to **1-514-288-3547**.

- Once the referral has been made, ask your patient to contact GRS Montreal to initiate their surgical booking: **1-514-288-2097** or info@grsmontreal.com. Please note some of these procedures are done in stages, requiring multiple trips to Montreal.
- If your patient wishes to submit an out of country application, please contact the Trans Care BC Care Coordination team at **1-866-999-1514** for further information.

Please ensure the following information is included at the time of a referral to GRS Montreal:

- Brief referral letter from GP or NP. Include any relevant clinical details not covered in the surgical recommendation form, e.g., BMI
- If > 6 months since assessment was completed, include an update of your patient's mental and physical health and readiness for surgery and communicate any significant changes that the surgical team needs to be aware of
- Copies of the surgical recommendation form(s) (Part A and Part B if required)
- If applicable- hysterectomy/BSO pathology report and operative report
- Any other relevant consult reports (e.g. recent cardiology, endocrinology reports)
- Consent to exchange information between GRS Montreal and TCBC (if applicable, this will be attached to the recommendation forms)
- Consent to exchange information between GRS Montreal and GP/NP (if applicable, this will be attached to the recommendation forms)

For more detailed information about any of these procedures please refer to the TCBC website at www.phsa.ca/transcare or transhealth.phsa.ca

If you require assistance in supporting your patient post-operatively, please contact the Trans Care BC Care Coordination team at **1-866-999-1514**. This team can also be accessed on an ongoing basis to support any clinical questions you may have. In addition, the RACE Line remains available to you. To access the RACE Line please call **604-696-2131** or toll free at **1-877-696-2131** and request the "Transgender Health" option.

Hope Air is a charity that provides free flights for financially disadvantaged Canadians for medically necessary travel. Should your patient require assistance with flight expenses please recommend they apply by filling in the online application at www.hopeair.ca. In some cases, Hope Air will also cover the costs for a companion to travel with the patient if deemed medically necessary. Hope Air will contact you to verify some details related to the patient's travel needs.

The Travel Assistance Program (TAP) is an option for assistance with transportation costs:

1. For eligible B.C. residents who must travel within province for non-emergency medical specialist services not available in their own community: www2.gov.bc.ca/gov/content/health/accessing-health-care/tap-bc/travel-assistance-program-tap-bc
2. Non-Local Medical Transportation Assistance: www2.gov.bc.ca/assets/gov/british-columbians-our-governments/policies-for-government/bc-employment-assistance-policy-procedure-manual/forms/pdfs/HR3320.pdf

Appendix G

Description of TCBC Care Coordination team

TRANS CARE BC
Provincial Health Services Authority

TRANS CARE BC
Our Services

We're a small team of health navigators, nurses, peers and support staff—with access to a doctor as needed.

We provide consultation, health navigation and care coordination services for gender-affirming health care across BC.

WE CAN HELP YOU:

- Find health & wellness resources
- Navigate the health care system
- Access health coordination for pre- & post-surgical care for surgeries taking place outside of BC.

WE SUPPORT:

- Youth, adults, children & families
- Caregivers, partners, teachers, friends
- Health care providers, social workers, counsellors & other service providers

WE WORK WITH SERVICE PROVIDERS TO:

- Promote best practices in gender-affirming client-centred care
- Provide clinical consultation & support
- Offer education opportunities to enhance trans health services across BC

CONTACT US

Call us toll-free at
1-866-999-1514
Monday – Friday

Email us at
transcareteam@phsa.ca

www.phsa.ca/transcare

WE BELIEVE IN:

- Gender-affirming care, inclusive of non-binary identities
- Being accountable & transparent in our work
- Taking an anti-oppressive & trauma informed approach
- Being person-centered
- Being equitable & accessible
- Being collaborative

VISION

A British Columbia where people of all genders are able to access gender-affirming health care, and live, work and thrive in their communities.

Appendix H

Referral form for gender affirming care coordination

TRANS CARE BC
Provincial Health Services Authority

CARE COORDINATION TEAM

Referral for gender affirming care coordination

Please complete the fields below as thoroughly as possible.

Date of referral (YYYY-MM-DD)		**Phone: 1-866-999-1514** **Fax completed form to: 604-675-7464**		
CLIENT DETAILS				
Last name:		**First name:**		
Legal name (as appears on CareCard):		Pronouns:		
PHN:		Date of birth (YYYY-MM-DD):	☐ **Under 18yrs?**	
Address:		City:		
Province:	Postal Code:	Email:		
Primary phone:		Message ok? ☐Yes ☐No	Phone type: ☐Home ☐Work	☐Cell ☐Other
Alternate phone:		Message ok? ☐Yes ☐No	Phone type: ☐Home ☐Work	☐Cell ☐Other
Primary language:		Interpreter required? ☐Yes ☐No		
Emergency contact name:				
Emergency contact relationship:		Emergency contact phone:		
PROVIDER INFORMATION				
Referral source		**Primary care provider (if different from referral source)**		
Name:		Name:		
Role:		Address:		
Phone:		Phone:		
Fax:		Fax:		

REFERRAL REASON(S)

Client has received a diagnosis of gender dysphoria ☐Yes ☐No

1. Surgical care planning (previously called assessment):

☐ First (1st) OR ☐ Second (2nd)

2. Information about Hormone therapy (Choose one):

☐ Masculinizing OR ☐ Feminizing

3a. Surgical care planning support

☐ Pre-surgical support ☐ Post-surgical support

4. Social issues:

☐ Housing ☐ Counselling ☐ Income assistance

☐ Other:

3b. Surgery type:

Upper surgery

☐ Chest surgery and contouring
☐ Breast construction surgery

☐ Surgery revisions (describe):
☐ Other surgery (describe):

Lower surgery - gonadectomy

☐ Hysterectomy/ bilateral salpingo-oophorectomy
☐ Orchiectomy

Lower surgery – Genital surgery

☐ Vaginoplasty (includes penectomy, orchiectomy)
☐ Phalloplasty
☐ Metoidioplasty
☐ Clitoral release
☐ Vulvoplasty

3c. Surgery date (if known):

CLIENT NAME:

MEDICAL HISTORY

Past medical history:

Please select any of the following that apply to your client:

- ☐ BMI 35 or above, BMI: _____(if known)
- ☐ Sleep apnea
  - CPAP machine ☐Yes ☐No
- ☐ Tobacco/nicotine use
- ☐ Cannabis/marijuana use
- ☐ Other substance use

Do you have any concerns regarding the stability of your client's physical or mental health? ☐ Yes ☐ No
If yes, please describe:

Surgical history:

Social issues which may impact treatment:

Current medications (attach list if available):

Allergies:

Other care providers involved (e.g., specialists, support workers, mental health team)

Name	Contact info	Organization	Relationship

Comments/additional information:

PROVIDER SIGNATURE

Provider name:	Signature	Date (yyyy-mmm-dd)


www.phsa.ca/transcare