**Gender Health SF**

 **Quality Care Form for Navigation & Care Coordination Services**

Gender Health SF is a program of the San Francisco Department of Public Health that provides culturally congruent peer-led gender-affirming navigation and care coordination services to assist patients through the consultation, informed consent, and surgical process for gender-affirming surgical care. Our mission is to ensure publicly insured and uninsured transgender and gender diverse (TGD) patients have an equitable opportunity to access necessary gender-affirming surgical care.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***This assessment requires primary care provider sign-off and may require mental health provider collaboration and sign-off; this should be determined by the patient’s care team.***

**Referring Provider, Agency, & Contact Information:**

Date of assessment: Click or tap to enter a date.

Referring Primary Care Provider’s name, email, & phone: Click or tap here to enter text.

Primary Care Clinic: Click or tap here to enter text.

Mental Health Provider’s name, email, & phone: Click or tap here to enter text.

Mental Health Clinic: Click or tap here to enter text.

Case Worker/other care coordinator & contact: Click or tap here to enter text.

Insurance Coverage: Click or tap here to enter text.

**Patient Information:**

Name: Click or tap here to enter text.

Legal Name (if different): Click or tap here to enter text.

Date of Birth: Click or tap to enter a date.

Pronouns: Click or tap here to enter text.

Gender Identity: Click or tap here to enter text.

Sexual Orientation: Click or tap here to enter text.

Race/Ethnicity: Click or tap here to enter text.

Phone #/Email: Click or tap here to enter text.

**Gender-Affirming Surgery(ies) Patient is Seeking:**

 Top Surgery: [ ]  Breast Augmentation [ ]  Chest Reconstruction

 Facial Surgery: [ ]  Feminization/Nonbinary [ ]  Masculinization/Nonbinary

 [ ]  Chondrolaryngoplasty (tracheal shave)

 Body Contouring: [ ]  Feminization/Nonbinary [ ]  Masculinization/Nonbinary

 Bottom Surgeries: [ ]  Orchiectomy [ ]  Hysterectomy

 [ ]  Vaginoplasty/Vulvoplasty (includes orchi)

 [ ]  Metoidioplasty/Phalloplasty (refer for hysto separately)

 Hair Restoration/Transplant: [ ]

 Not Listed: [ ]  Click or tap here to enter text.

**SECTION 1-4 COMPLETED BY BEHAVIORAL HEALTH PROVIDER OR PCP:**

**Name, Title, License:** Click or tap here to enter text.

**Date**: Click or tap to enter a date.

**\*If the person completing sections 1-4 is not licensed, please include licensed supervisor information**

**Licensed Supervisor (if needed):**

**Name, Title, License:** Click or tap here to enter text.

**Date**: Click or tap to enter a date.

1. Patient has documented diagnosis of gender dysphoria or gender incongruence. Yes/No, add additional information if needed.

Click or tap here to enter text.

1. Patient has the capacity to make a fully informed decision and consent to treatment. Yes/No, add additional information if needed.

Click or tap here to enter text.

1. Clinical and Care Considerations: *Please address significant clinical considerations and/or recommendations to help GHSF and surgeons provide more effective care.*
	1. Social, spiritual, and cultural

Click or tap here to enter text.

* 1. Protective factors and strengths

Click or tap here to enter text.

* 1. Language(s) and literacy

Click or tap here to enter text.

* 1. Neurodiversity, learning, and cognitive access

Click or tap here to enter text.

* 1. Mental Health (*diagnosis & current management, state of stability, history of suicidal ideation/attempt, harm to self or others*)

Click or tap here to enter text.

* 1. Smoking/vaping tobacco and/or nicotine use: Click or tap here to enter text.

i. Cessation plans: Click or tap here to enter text.

* 1. Smoking/vaping cannabis

Click or tap here to enter text.

* 1. Substance/Alcohol use (*current/past significant use, relapse, or harm reduction plan*)

Click or tap here to enter text.

1. Pre- and Post-Surgery Plan: Planning for surgical recovery is essential to optimal surgical outcomes and helps reduce the need for revision surgery.
2. Personal support network, designated specific support person/people, and contact info

Click or tap here to enter text.

1. Transportation—to and from surgery and post-op appointments

Click or tap here to enter text.

1. Housing status—stability, safety, access to bathroom/clean water, privacy

Click or tap here to enter text.

1. Food access needs

Click or tap here to enter text.

1. Mental Health and/or substance use support plan if relevant

Click or tap here to enter text.

1. Primary Care Plan: [ ]  Yes, I have reviewed the following primary care plan with patient.
	* 1. PCP visit 3 months prior to surgery: order supplies, document medical and mental health clearance.
		2. PCP visit 1-2 weeks prior to surgery for pre-op labs, Health at Home & Project Open Hand referrals.
		3. PCP visit 1-2week post-op surgery via telehealth.

**SECTION 5. COMPLETED BY PCP ONLY:**

**Name, Title, License:** Click or tap here to enter text.

**Date**: Click or tap to enter a date.

1. Health History: Please document current or historically relevant health history that could impact surgical readiness. *Note surgeon practices may have their own specific requirements for assessing surgical readiness, substance use and nicotine screenings, sobriety, and smoking cessation.*
	1. Medical conditions:
		1. Current BMI and any weight management considerations (*i.e., plans for significant weight loss or gain, disordered eating, planned bariatric surgery*):

Click or tap here to enter text.

* + 1. If the patient has Diabetes, current A1c (within past 3mo) - if greater than 7.5, describe the plan for improving BS control to this goal:

Click or tap here to enter text.

* + 1. Cardiovascular, pulmonary disease, and/or other significant health conditions:

Click or tap here to enter text.

* + 1. History of gender-affirming surgeries:

Click or tap here to enter text.

* + 1. History of hormone use:

Click or tap here to enter text.

* 1. Physical access needs (*I.e., mobility status, hearing, etc.):*

Click or tap here to enter text.

* 1. Fertility goals and counseling:

Click or tap here to enter text.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

By completing this document, I acknowledge that I am available to consult on care coordination and navigation needs with Gender Health SF. This patient meets WPATH SOC8 criteria for gender-affirming surgery and I fully support this patient moving forward with gender-affirming surgical care.