Spectrum:
The Other Clinic
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Referral Form Below To Be Completed By Licensed Mental Health Professional

Patient: _____
Date of Birth: _____
Birth Gender: _____
Current Gender Described By Them: _____

The patient listed above has been under my care recently. I am referring them for initiation of hormone therapy. My signature below certifies that I agree with the following statements:

1) **I have diagnosed the patient with Gender Dysphoria as per DSM-V criteria.**
2) **The patient's mental health status is stable at the time of this form completion.**
3) **The patient is currently residing in a reasonably supportive home environment conducive to initiating transitional hormone therapy.**
4) **The patient is mentally competent enough to help make their medical decisions.**

Do you require them to continue therapy during medical transition, or would you say it is optional: _____

Do you have any areas of concern that we should know about?_____
_____
_____

What, if any, concurrent mental health diagnoses does the patient also have:_____
_____
_____

Anything Else?_____
_____
_____

Printed Name Of Practitioner Completing:_____

Signature / Date:_____ / _____