

**Northern Region Gender Dysphoria Service (NRGDS)**

**Referral Form**

NRGDS, based at Walkergate Park Hospital, Newcastle is a service for people who experience persistent confusion and/or distress with their gender. This includes people who want to change physical aspects of their gender as well as those who do not. **The service is available to people over the age of 17 who live in England.** Children and young people should be referred to the [National Referral Support Service for the NHS Children and Young People's Gender Service](https://www.ardengemcsu.nhs.uk/services/clinical-support/national-referral-support-service-for-the-nhs-gender-incongruence-service-for-children-and-young-people/).

Please note, people aged 17 will **not** be able to receive an appointment until they turn 18.

You can use this form to refer yourself or make a referral for somebody else, provided you have their consent to do so. Please complete the form as fully as possible to ensure that the referral is accepted. Please note, when referrals do not originate from the General Practitioner (GP), we will share all the information in this referral form with the GP to ensure they are aware of the referral and agree in principle to prescribe medication recommended by NRGDS and to carry out investigations required to manage hormone treatment within current NHS England guidelines.

In making or agreeing to a referral, GPs are assumed to agree.

All sections with an \* must be completed.

**Date of referral**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| \*NHS Number: |  | | | Historical NHS No: | | | |  |
| \*DOB  **Must be 17+** | DD/MM/YYYY | | \*Pronouns | | | He/Him/His  She/Her/Hers  They/Them/Theirs  Other, please specify \_\_\_\_\_\_\_\_\_\_ | | |
| \*Name on GP records |  | | | | | | | |
| \*Name to use for | Post:  Phone calls: | | | | Emails:  In-person: | | | |
| \*Gender Identity as described: |  | | | | | | | |
| \*Sex assigned at birth: | Male  Female | | | | | | | |
| Is there history of an intersex condition? If yes, please give details. | |  | | | | | | |
| \*Ethnicity | Asian or Asian British  Bangladeshi  Indian  Pakistani  Any other Asian background  Black or Black British  African  Caribbean  Any other Black background  Mixed  White & Asian  White & Black African | | | | | | White & Black Caribbean  Any other mixed background  White  British  Irish  Any other White background  Other Ethnic Group  Chinese  Any other ethnic group  I do not wish to disclose this | |

**Contact Details**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| \*Address:  Inc. post code |  | | | | |
| Receive letters via email or post? | Email  if yes, please provide the email and tick consent box below  Post | | | | |
| Email: |  | | Mobile Tel No: | |  |
| \*Consent to contact you via: | Text  Email | \*Can the person you are referring attend independently? | | No  Yes  If no, please give details: | |
| \*Interpreter required? | No  Yes  If yes, what language? | | | | |

**GP details**

|  |  |  |  |
| --- | --- | --- | --- |
| GP Name: |  | \*GP Practice Name: |  |
| \*GP Practice Address:  Inc. post code |  | | |
| GP Tel No. |  | GP Email |  |

**Referrer’s details (if different to GP above)**

|  |  |  |  |
| --- | --- | --- | --- |
| \*Is this a self-referral? **If yes, please skip this section** | Yes  No | | |
| Referrer’s Name: |  | Job title: |  |
| Relationship to person you are referring: |  | | |
| Referrer’s Address: |  | | |
| Referrer Tel No. |  | | |
| Referrer Email: |  | | |

**Please provide us with detailed reasons for the referral.**

Please include:

* Gender identity, their feelings about it and how these may have changed and developed over time.
* The impact on psychological wellbeing, social functioning, relationships and support networks.
* Their hopes and goals for the future – what do they want to happen?
* Whether they have attended this clinic in the past or have attended/are currently attending another gender clinic (including NHS and/or private clinics) – please include details of any past or current treatments.  
  *NB: If the person is currently receiving care or waiting for another NHS Gender Identity Service, please contact their current clinic to discuss options for transferring their care.*

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**Substance use**

|  |  |  |  |
| --- | --- | --- | --- |
| Smoker or any nicotine use including vaping? | Yes  No | If yes, details: |  |
| Alcohol consumption? | Yes  No | If yes, units per week: |  |
| Recreational drug use? | Yes  No | If yes, details: |  |

**Does the person have any current or historical medical conditions including an intersex condition? If so please state below**

*The referrer (if not the GP) may need to liaise with the GP for some of this information. Please include details of any surgery.*

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**Does the person have any difficulties with their mental health?**

*Please provide details of any past or current mental health history that you are aware of, including details of any other agencies that are/have been involved with the person. The referrer (if not the GP) may need to liaise with the GP for some of this information. NB NRGDS is not a general mental health service, if the person requires support with their mental health please refer to the relevant service.*

*Write on next page*

|  |
| --- |
| Click here to enter text. |

**Is there any history or risk to self or others?**

*Please give details of any current or historical suicidal or self-harm behaviour, any harm from others including domestic violence or exploitation and any convictions, cautions or licenses including any MAPPA and MARAC.*

|  |
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|  |

**Does the person have any diagnosis or symptoms of neurodivergence (such as autism or ADHD) or an intellectual disability?**

|  |
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|  |

**Is there a family history of any of the following?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Condition** |  | **Details** | **Condition** |  | **Details** |
| Deep vein thrombosis (DVT) or Pulmonary embolism (PE) | Yes  No |  | Diabetes | Yes  No |  |
| Stroke | Yes  No |  | Cancer | Yes  No |  |
| Heart Disease | Yes  No |  | Other | Yes  No |  |

**Medication Assessment**

Please provide details of any NHS prescribed medication the person is currently taking, including sex hormones and hormone blockers (this may be a computerised print-out from GP record):

|  |  |  |
| --- | --- | --- |
| Name of Medication | Dose | Duration |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |

Please provide details of any known non-NHS prescribed sex hormones and hormone blockers that the person is taking:

|  |  |  |
| --- | --- | --- |
| Name of Medication | Dose | Details (e.g. how sourced, private prescription, duration of taking). |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |  |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |

Please provide further information below (not already included above) about the person, if relevant.

|  |
| --- |
| Click here to enter text. |

**Please return this form to:**

Northern Region Gender Dysphoria Service

Northumberland, Tyne and Wear NHS Foundation Trust

Benfield House

Walkergate Park

Benfield Road

Newcastle upon Tyne

NE6 4QD

Tel: 0191 287 6130

Email: [NRGDS@cntw.nhs.uk](mailto:NRGDS@ntw.nhs.uk)