GP Completed Gender Affirming (Genital) Surgery: Health and Wellbeing

Te Whatu Ora
Health New Zealand

- This form and all its fields must be completed and signed by the patient's general practitioner (GP) before returning it to **gender.surgery@health.govt.nz**
- If any fields on this form are not completed, this form will be returned to the patients GP to complete.
- This is a fillable form, if you wish to fill it out on your computer you will need to download the form to your computer and save it before starting to fill it out.

Patient contact details

Name

Date of birth

Ethnicity

Pronoun(s)

NHI number

Address (street number and name)

Suburb

City

Post code

Email

Phone (mobile)

Phone (other)

GP name and practice

Are you the patients usual doctor? ◯ Yes ◯ No

Do you know the patient's medical history? ◯ Yes ◯ No

Patient's support person contact details

Name

Relationship with patient

Email

Phone

General

Is the patient still wishing to access gender affirming genital surgery? ◯ Yes ◯ No

Is the patient eligible for publicly funded health care in New Zealand?* ◯ Yes ◯ No

Has the patient had a psychological readiness assessment completed? ◯ Yes ◯ No

If Yes, when was it (date) and please attach a copy

Has the patient accessed hair removal? ◯ Yes ◯ No

If Yes, please describe (eg, facial/full body)

Patient health and wellbeing

Height (cm) | Weight (kg) | BMI

Note: Calculate your BMI at **heartfoundation.org.nz/wellbeing/bmi-calculator**

Does the patient smoke (cigarettes or vaping)? ◯ Yes ◯ No

If yes, please refer patient to the following smoking cessation websites:

https://www.smokefree.org.nz/help-advice/stop-smoking-services **https://quit.org.nz/**

Does the patient drink alcohol? ◯ Yes ◯ No If Yes, how many units per week?

Does the patient use recreational drugs? ◯ Yes ◯ No

If yes, what drugs?

Note: Smoking, excessive alcohol consumption and the use of recreational drugs could impact the patients progress and access to the service. If the patient requires support, please refer them on to their local alcohol and other drugs (AOD) services.

Has the patient's mental health and wellbeing been stable for the last 12 months? ◯ Yes ◯ No

As the patients GP, can you please provide an update in the box below of the patient's mental health and wellbeing in the last 12 months?

Are there any mental health records available from the past 12 months? ◯ Yes ◯ No

Note: If yes, please provide this information or any relevant information regardng the patients mental health.

What is the patient's level of fitness?

Does the patient have a physical disability? ◯ Yes ◯ No

If Yes Please describe

Does the patient easily get out of breath when they exercise? ◯ Yes ◯ No

Does the patient get breathless when lying down? ◯ Yes ◯ No

If yes, how many pillows do they use to sleep comfortably and in what position do they sleep comfortably?

Does the patient snore, or have obstructive sleep apnoea? ◯ Yes ◯ No

If yes, does the patient use a CPAP machine at home? ◯ Yes ◯ No

Does the patient have any of the following medical conditions?

High blood pressure ◯ Yes ◯ No

Please describe

Transmissible diseases ◯ Yes ◯ No

Please describe

Allergies (if yes, what are they allergic to?) ◯ Yes ◯ No

Please describe

Kidney or liver disease ◯ Yes ◯ No

Please describe

Diabetes (if yes, what is the patients most recent HbA1c/blood sugar test result?) ◯ Yes ◯ No

Please describe

History of cancer ◯ Yes ◯ No

Please describe

Heart condition (irregular heartbeat, angina, heart attack, cardiac stents, valve disease or cardiac surgery) ◯ Yes ◯ No

Please describe

Respiratory conditions (eg, asthma, tuberculosis, COPD) ◯ Yes ◯ No

Please describe

Nervous system conditions (eg, stroke, epilespsy, Parkinson's) ◯ Yes ◯ No

Please describe

Chronic pain (eg, frequent headaches, nerve damage pain, arthritis) ◯ Yes ◯ No

Please describe

Inflammatory, connective tissue or rheumatological conditions
(eg, rheumatoid arthritis, lupus, scleroderma, gout, Marfan syndrome) ◯ Yes ◯ No

Please describe

Blood disorders (blood clots, anaemia, transfusion problems) ◯ Yes ◯ No

Please describe

Does the patient have any transplanted devices?
(eg, drug delivery pump, cardiac pacemaker, nerve stimulator) ◯ Yes ◯ No

Please describe

Has the patient been prescribed steroid pills in the past six months? ◯ Yes ◯ No

Please describe

Is the patient on any anticoagulation medication? (eg, thromboembolism) ◯ Yes ◯ No

Please describe

Please list any medicine the patient is taking

Please list any operations this patient has had and when it took place.

What	When

Is there any other relevant health information on this patient to be disclosed?

Signature

GP registration number	GP signature	Date

Email the completed form to: **gender.surgery@health.govt.nz**