Transgender Health Services  
Surgery Referral Patient Summary Sheet

Instructions:
• Please fill out this form and fax to (415) 355-7407 to initiate a referral for your patient to transgender surgery.
• Four (4) additional documents are required for your referral to be complete and ready for processing; these are listed at the bottom of this page.
• Once all documents are received, Transgender Health Services will initiate the prior authorizations needed for pre-surgery consultation.
• If the patient needs multiple surgeries, please submit separate forms for each surgical procedure.

Date: ___________________

Patient’s Name: _____________________________________________________________
Patient’s Legal Name (if different): ____________________________________________
DOB: ____________
Surgery Procedure Requested: ___________________________
Insurance: ________________________________

Primary Care Provider Name: ______________________________
Phone: ______________________________
Fax: ______________________________
Best Care Team Member for THS to contact (if not primary care provider):
Name: ______________________________
Role: ______________________________
Phone: ______________________________

Please also fax the following documents for a complete surgery referral:
1) Medical Evaluation Form – to be completed by PCP
2) Patient Education Form – to be completed by any care team member
3) 2 psychosocial assessments by licensed mental health providers with letters documenting assessment
4) Proof of enrollment in Medi-Cal Managed Care or Healthy San Francisco

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