Date: / /

Dear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,  
 (*Prescriber)*

|  |  |
| --- | --- |
| Client’s preferred name |  |
| Date of birth |  |
| Full address |  |
| Medicare number |  |

**Re:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
 *(Client’s preferred name)*   
  
has requested to visit our service for administration of Gender Affirming Hormonal Therapy (GAHT) that you have prescribed for them.

Prior to future administration by our team, we require the attached referral form to be completed and returned via fax to **(03) 8470 1107** or via email to our Practice Nurse at **practicenurse@yourch.org.au**

Please also find attached a completed Patient Authority - Consent for Sharing of Medical Records form on page 2.

Yours sincerely,

**Your Community Health**

|  |  |
| --- | --- |
|  |  |

**PATIENT AUTHORITY - Consent for Sharing of Medical Records**

***Client to complete***

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pronouns \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(Preferred name of client)*

of, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(Address of client)*

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorise, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 *(Name of GAHT prescriber & Clinic)*

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

to release my medical information to:

Your Community Health

East Reservoir Clinic

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: / /

**GAHT – External Prescriber Safe Access Form  
*Prescriber to complete***

|  |
| --- |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Prescriber name** |  | | | |
| **Clinic name & address** |  | | | |
| **Endocrinologist name & contact details (if applicable)** |  | | | |
|  | | | | |
| **Medical history** |  | | | |
| **Current medications** |  | | | |
|  | | | | |
| **Medication** (name & dose) |  | | | |
| **Date prescribed** |  | | | |
| **Current dose interval** (weeks) |  | | | |
| **Date GAHT initiated** |  | | | |
| **Date of last GAHT administration** |  | | | |
|  | | | | |
| **Last blood test date** |  | | | |
| **Relevant results** | Oestradiol | Free testosterone | Testosterone | HCT |
| **Next blood test date** |  | | | |
| **Current blood test interval** |  | | | |
| **Next appointment date  with prescriber** |  | | | |

**GAHT – External Prescriber Safe Access Form   
*Prescriber to complete***

I, *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
(Prescriber name)*

Consent to the administration of the above listed GAHT at **Your Community Health**, to,

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

*(Legal name of client & date of birth)*

Prescriber Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_