



DENVER HEALTH LGBTQ HEALTH SERVICES™

A CENTER OF EXCELLENCE

Name:		Pronouns:		Legal Name:	
Address:		City, State, Zip:			
Phone:		Email:			
Date of Birth:		SSN:			
Gender Identity:		Sexual Orientation:		Sex Assigned at Birth:	
Race:		Marital Status:			
Height:		Weight:			
Smoker:		<input type="checkbox"/> Yes		<input type="checkbox"/> No	
Are you currently receiving Primary Care?		<input type="checkbox"/> Yes		<input type="checkbox"/> No	
Primary Care Provider Name:					
Are you currently receiving Behavioral Health services?		<input type="checkbox"/> Yes		<input type="checkbox"/> No	
Behavioral Health Provider Name:					
Living Full-Time in Preferred Gender Role (MM/YYYY):					
Hormone Therapy Start Date:					
Emergency Contact		Name:			
		Phone:		Relationship to Patient:	
Are you a veteran?		<input type="checkbox"/> Yes		<input type="checkbox"/> No	
		Birth Country/Nationality:			
Are you employed?		<input type="checkbox"/> Yes		<input type="checkbox"/> No	
		<input type="checkbox"/> Full-Time		<input type="checkbox"/> Part-Time	
		<input type="checkbox"/> N/A			

I am interested in obtaining the following:

****IF YOU SELECT MULTIPLE SURGERIES - PLEASE INDICATE WHICH ONE YOU WOULD LIKE TO WORK TOWARDS FIRST****

<input type="checkbox"/> Mastectomy/Chest Reconstruction	<input type="checkbox"/> Simple Metoidioplasty (COMING SOON)
<input type="checkbox"/> Breast Augmentation*	<input type="checkbox"/> Tracheal Shave (Cash-Pay)
<input type="checkbox"/> Orchiectomy (Removal of testes)	<input type="checkbox"/> Voice Therapy (Cash-Pay)
<input type="checkbox"/> Hysterectomy (Removal of uterus)	
<input type="checkbox"/> Vaginoplasty	

*Insurance may not cover

Please include a picture of your insurance card and photo ID!

Name of Insurance:	Policy #:
Name on Insurance Card:	Group # (if applicable):

Denver Health requires candidates to meet requirements set by the World Professional Association for Transgender Health (WPATH) version VII and clinic guidelines. Additional information may be needed to meet the needs of your insurance plan.

Email form back to Hope.Anderson@dhha.org | Fax number: 303-602-3676