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: ☐ Yes ☐ No		

Are you currently receiving Primary Care?	☐ Yes	☐ No
Primary Care Provider Name:		
Are you currently receiving Behavioral Health services?	☐ Yes	☐ 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?	☐ Yes	☐ No	**Birth Country/Nationality:**		
Are you employed?	☐ Yes	☐ No	☐ Full-Time	☐ Part-Time	☐ 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

☐ **Mastectomy/Chest Reconstruction**	☐ **Simple Metoidioplasty *(COMING SOON)***
☐ **Breast Augmentation***	☐ **Tracheal Shave (Cash-Pay)**
☐ **Orchiectomy (Removal of testes)**	☐ **Facial feminization surgery (Cash-Pay)**
☐ **Hysterectomy (Removal of uterus)**	☐ **Voice Therapy (Cash-Pay)**
☐ **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