Health New Zealand
Te Whatu Ora

Gender-affirming genital surgery (GAgSS) Referral

This application form **ONLY** applies to gender affirming **genital** feminising or masculinising surgery. See the Gender-affirming genital surgery service (GAgSS) website for surgical procedures provided, clinical criteria and surgical information resources.

https://www.tewhatuora.govt.nz/health-services-and-programmes/providing-health-services-for-transgender-people/the-gender-affirming-genital-surgery-service/

Please direct referrals for **ALL** other gender affirming surgery to the appropriate local district hospital provider.

The following criteria **MUST** be met to consider a referral for gender-affirming (genital) surgery.

Eligibility: Is this person eligible for publicly funded services as defined in the NZ Public Health and Disability Act 2000

☐ Yes ☐ No

More information on eligibility is at: https://www.tewhatuora.govt.nz/corporate-information/our-health-system/eligibility-for-publicly-funded-health-services/eligibility-explained/

Meets GAgSS criteria: To be considered for a first specialist assessment a person must be at least 18 years of age,

☐ Yes ☐ No

Meets GAgSS criteria: Persistent, well-documented gender dysphoria/incongruence and capacity to make a fully informed decision and to consent for treatment

☐ Yes ☐ No

Evidenced with Clinical letter or Report.

Meets GAgSS criteria: 12 continuous months of hormone therapy as appropriate to the patient's gender goals.

☐ Yes ☐ No

Evidenced with Clinical letter or Report.

Meets GAgSS criteria: 12 continuous months of congruently living in their authentic gender (opposed to sex assigned at birth)

☐ Yes ☐ No

Evidenced with Clinical letter or Report.

Meets GAgSS criteria: BMI Less than 35 (Patients on the waiting list will not be progressed or offered surgery unless their BMI is below 30 - those with a BMI of 30-35 are expected to be working on healthy weight reduction with their GP to-achieve a BMI of less than 30 while on the waiting list.)

☐ Yes ☐ No

Meets GAgSS criteria: Nicotine free/ non-smoker (including nicotine based vapes and nicotine replacement therapy (NRT). To be considered nicotine free/ a non-smoker patient MUST be nicotine free for more than 3 months prior to date of referral.

☐ Yes ☐ No

This patient referral form and all its fields must be completed by an authorised GP (the districts where authorised GPs can make referrals are currently only Wellington and Christchurch) or district hospital referrer.

This patient referral form must be accompanied with the following:

- **A report/clinic or summary letter documenting a diagnosis of gender dysphoria/incongruence and capacity to make a fully informed decision and to consent for treatment.**

Where available include:

- **Report/Clinic letter documenting gender affirming hormone commencement**
- **Report/Clinic letter documenting any other gender affirming surgical interventions.**

The **referral and accompanying** documents must be submitted to gender.surgery@tewhatuora.govt.nz

O Please note: 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. Please note: **ALL fields** must be filled in.

O This patient referral form and all its fields must be completed by the patients GP or district hospital referrer and submitted to gender.surgery@tewhatuora.govt.nz

Checklist

Prior to submitting this application, please ensure that you have completed and/or included:

☐ Section 1 – Patient details

☐ Section 2 – Referrer Information

☐ Section 3 – Reason for Referral

☐ Section 4 – Referral Criteria

☐Section 5 – Additional Patient Information

☐ Section 6 – Attached supporting documents

☐ Section 6 – Signatures

Section 1 - Patient's details

(Required)

First name/s

Last name

Legal Name if differs from name above (Required)

First name/s

Last name

Pronouns (Required)

NHI number (Required)

Date of birth (Required)

Gender (Required)

Sex assigned at birth (Required)

Ethnicity (Provide the ethnicity as self-reported by the patient. The patient may select more than one ethnic group.)

Current New Zealand Address (Required)

City

Post code

District hospital and region

Phone (Required)

Email (Required)

Name of GP and practice (Required)

GP Email Address (Required)

Eligible for publicly funded treatment in New Zealand ☐ Yes ☐ No
(See Note1 at back of this form for eligibility criteria)

Are you the patient's usual doctor? ☐ Yes ☐ No

If no, please provide details of usual Doctor.

Do you know their medical history? ☐ Yes ☐ No

Do you know their mental health history? ☐ Yes ☐ No

Does patient speak English? ☐ Yes ☐ No

If not what is the primary language?

Does patient require an interpreter? ☐ Yes ☐ No

Does patient have a physical disability? ☐ Yes ☐ No

If Yes please describe

Section 2 - Referrer information

Name

Consultation by

☐ District hospital ☐ GP

Your specialty

Referring district hospital and region

Referrers New Zealand Medical Council number

Email

Phone number

Section 3 – Reason for Referral

NB: referral for surgery on reproductive organs (hysterectomy, salpingo-oophorectomy and orchidectomy) need to be made separately via local pathway and prior to a referral to the GAgSS.

Information on the various procedures the Service provides is available on our website.
https://www.tewhatuora.govt.nz/health-services-and-programmes/providing-health-services-for-transgender-people/the-gender-affirming-genital-surgery-service/

Please indicate which Gender Affirming genital Surgery the patient is seeking

Procedure:

Feminising ☐

Full depth Vaginoplasty ☐

Minimal Depth Vaginoplasty ☐

Unsure ☐

Masculinising ☐

Metoidioplasty ☐

with urethral lengthening ☐

without urethral lengthening ☐

Unsure ☐

Phalloplasty ☐

with urethral lengthening ☐

without urethral lengthening ☐

Unsure ☐

Section 4 – Referral Criteria

Meets GAgSS criteria ☐ Yes ☐ No

NB: Patient not meeting GAgSS criteria will not be considered for First Specialist Assessment

Duration of social affirmation (transition) _____ years

NB: minimum 12 continuous months of living in a gender ~~role~~ that is congruent in their gender ~~role~~ is required to meet criteria.

Duration of continuous Gender Affirming Hormone Therapy _____ years

NB: minimum 12 continuous months of hormone therapy required to meet criteria.

Patients Height (cm) _____ Weight (kg) _____ BMI _____

NB: BMI must be less than 35 to be considered for referral acceptance; BMI must be less than 30 to be considered for surgery.

Do they smoke? ☐ Yes ☐ No Do they vape nicotine? ☐ Yes ☐ No

If an ex-smoker, length of time nicotine free inc. vapes and nicotine replacement therapies (NRT)

_____ months/years

NB: Must be Nicotine free for more than 3 months to meet criteria.

Section 5 – Additional Patient Information

Have they had any readiness assessments for any form of gender affirming care? ☐ Yes ☐ No (If **YES** please attach)

Provider _____

Have they had any previous gender-affirming surgical procedures ☐ Yes ☐ No

(If YES please indicate gender-affirming procedure(s), including where, when and any complications – discharge summary if available)

Top Surgery: Breast Augmentation ☐ Chest Masculinisation/Mastectomy ☐

Facial Surgery: Feminisation ☐ Masculinisation ☐

Tracheal shave (Chondrolaryngoplasty) ☐

Vocal cord / pitch surgery (laryngoplasty) ☐

Reproductive organ surgery: Orchiectomy ☐ Hysterectomy ☐

Any additional information?

Does the patient have any of the following medical conditions?

If 'Yes' please describe and attach related clinical and patient notes.

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 (e.g., asthma, tuberculosis, COPD) ☐ Yes ☐ No

Please describe

Nervous system conditions (e.g., stroke, epilepsy, Parkinson's) ☐ Yes ☐ No

Please describe

Chronic pain (e.g., frequent headaches, nerve damage pain, arthritis) ☐ Yes ☐ No

Please describe

Inflammatory, connective tissue or rheumatological conditions

(e.g., 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?

(e.g., 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? (e.g., thromboembolism) ☐ Yes ☐ No

Please describe

Is patient condition stable ☐ Yes ☐No

If Yes, How long. If No, **please state**

Current and past mental health (List **all** conditions, including any past and present mental health/ addiction problems, any current support and any social issues)

If applicable please include all secondary care mental health records, particularly discharge summaries

Is patient condition stable ☐ Yes ☐No

If Yes, How long. If No, **please state**

All current Medications including dosage

Section 6 - Attached supporting documents:

Required attachment:	Attached:
• Report/Clinic letter documenting a diagnosis of gender dysphoria/incongruence and capacity to make a fully informed decision and to consent for surgical treatment (readiness assessment or equivalent).	☐Yes

Supporting attachment(s) (where they exist):	Attached:
• Report/Clinic letter documenting gender affirming hormone therapy commencement.	☐Yes ☐No
• Report/Clinic letter documenting other gender affirming surgical interventions.	☐Yes ☐No
• Mental Health Records (where available)	☐Yes ☐No
• All relevant clinical notes and any other supporting documentation.	☐Yes ☐No

Section 7 - Signature

Please sign and return this form.

Referrer Name _____ Date _____

Referrer Signature _____

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

Notes:

1. Eligibility: The following people are eligible:
   a. New Zealand Resident Class Visa Holders
   b. New Zealand citizens (including those from the Cook Islands, Niue or Tokelau)
   c. Australian citizens or permanent residents who have lived, or intend to live, in New Zealand for two years or more
      work visa holders eligible to be in New Zealand for two years or more
   d. interim visa holders
   e. New Zealand Aid Programme students receiving Official Development Assistance (ODA) funding
   f. commonwealth scholarship students
   g. foreign language teaching assistants
   h. refugees and protected persons, applicants and appellants for refugee and protection status and victims of people trafficking offences.

More information on eligibility is at: https://www.tewhatuora.govt.nz/corporate-information/our-health-system/eligibility-for-publicly-funded-health-services/eligibility-explained/