MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

ADULT SERVICE INQUIRY FORM

University of Michigan Medical Record Number: _____

Date: _____

Legal last name: _____ Legal first name: _____

Preferred last name: _____ Preferred first name: _____

Pronouns: She/her ☐ He/his ☐ They/them ☐ Other: _____

Sex assigned at birth: F ☐ M ☐ Intersex ☐

Current legal sex: F ☐ M ☐

Gender: Trans woman ☐ Trans man ☐ Genderqueer ☐ Two spirit ☐ Other:_____

DOB: _____ Current age: _____

Race/Ethnicity: _____

Marital status: Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐ Separated ☐

Address: _____

City, State, Zip: _____

Preferred phone number: _____ OK to leave message? Y ☐ N ☐

Alternate phone number: _____ OK to leave message? Y ☐ N ☐

Best days/times to call: _____

Email address: _____

SERVICES DESIRED

Please check all that apply.

Counseling/therapy		Facial Feminization Surgery		Breast Augmentation	
Primary Care Doctor		Hysterectomy		Metoidioplasty	
Hormones		Oophorectomy		Phalloplasty	
Hair Removal		Orchiectomy		Vaginoplasty	
Voice Therapy		Mastectomy & Chest Reconstruction			

Other services: _____

Do you have a therapist who has experience working with transgender clients? Yes ☐ No ☐

If yes, therapist's name: _____ Therapist's phone number: _____

Medical/surgical treatments you have had: (Check all that apply.)

No medical or surgical treatments		Reduction thyroid chondroplasty	
Cross sex hormone therapy, currently using		Laryngeal feminization surgery	
Cross sex hormone therapy, past user		Voice surgery	
Mammoplasty		Scalp advancement	
Hysterectomy		Forehead reconstruction	
Oophorectomy		Soft tissue filler injections	
Vaginectomy		Breast augmentation	
Phalloplasty		Orchiectomy	
Metoidioplasty		Penectomy	
Urethroplasty		Vaginoplasty, penile inversion	
Scrotoplasty		Vaginoplasty, colon graft	
Salpingectomy		Other unlisted surgical procedure	

If you are interested in hormones or surgery, we will not able to assist until we receive a signed release of information to speak with your therapist. Below is a link to a release to fill out, sign, and return with this form.

http://www.med.umich.edu/i/him/Forms/OtherThanConsents/Institutional/70-10072_Authorization-ForClinicalCommunication.pdf

Return completed forms via:

Fax: 734-998-2152

OR

Email: genderservices@med.umich.edu

OR

US Mail:

UM Comprehensive Gender Services

2025 Traverwood Drive, Suite A1

Ann Arbor, MI 48105

By returning this completed form, you consent to this information becoming part of your electronic medical record at the University of Michigan Health System.

Notes: _____

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