MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

Date: _____

ADULT SERVICE INQUIRY FORM

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

Michigan Medicine Medical Record Number: _____ *If you don't know your MRN, leave this field blank.*

Legal first name: _____ Legal last name: _____

Date of Birth: _____

Current legal sex: ☐ F ☐ M *Please make sure that your answer to this question matches your legal sex according to your insurance provider.*

PLEASE READ THIS SECTION

If you provide your preferred name, gender identity, and pronouns on this form, **we will add this information to your electronic medical record.** This information will be available to all health care providers and staff using the Michigan Medicine electronic medical record system. **It is your choice whether or not you provide the information in this box, below.** If you provide the information:

- Providers, staff, and automated systems (including automated appointment reminders) should use your preferred name when communicating with you.
- Office visit notes from Michigan Medicine providers should include your preferred name and pronouns.
- Clinic staff may use your preferred name when they call you from a waiting room.
- Your gender identity will appear in addition to your legal sex at various places in your chart.
- If you receive care from a non-Michigan Medicine hospital or emergency room that can access Michigan Medicine's electronic medical record, that other health care system may see your preferred name, pronouns, and gender identity.
- If a Michigan Medicine provider refers you to a non-Michigan Medicine facility, your preferred name and gender identity may appear along with your legal name and sex.

You may leave any part of this section blank.

Preferred first name: _____ Preferred last name: _____

Gender: ☐ Trans woman ☐ Woman ☐ Trans man ☐ Man ☐ Genderqueer ☐ Two spirit ☐ Nonbinary ☐ Other: _____

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

Race/Ethnicity: _____

Address: _____

City, State, Zip: _____

Preferred phone number: _____ OK to leave message? ☐ Yes ☐ No
Type: Home ☐ Mobile ☐ Work ☐ Other ☐ _____

Alternate phone number: _____ OK to leave message? ☐ Yes ☐ No
Type: Home ☐ Mobile ☐ Work ☐ Other ☐ _____

Best days/times to call: _____

Email address: _____

Services Desired

(Check all that apply.)

- ☐ Counseling / Therapy
- ☐ Trans Adult Support Group
- ☐ Parent Support Group
- ☐ Partner Support Group
- ☐ Primary Care Doctor
- ☐ Hormones - New
- ☐ Hormones - Transfer
- ☐ Hair Removal
- ☐ Voice Training
- ☐ Facial Feminization Surgery
- ☐ Hysterectomy
- ☐ Oophorectomy
- ☐ Orchiectomy
- ☐ Surgery Revision -- Surgery to Revise: _____
- ☐ Fertility Preservation
- ☐ Vaginoplasty
- ☐ Metoidioplasty
- ☐ Phalloplasty
- ☐ Breast Augmentation
- ☐ Mastectomy/Chest Reconstruction
- ☐ Other services: _____

How should CGSP send you further information on the services you are interested in?
(Please choose only 1)

☐ **Email** - CGSP will use the email address you provided on page 1 of the form. If you would like CGSP to use a ***different*** email address, please provide it here: _____

☐ **Mail** - CGSP will use your preferred name and the mailing address you provided on page 1 of the form. If you would like CGSP to use a ***different*** name or mailing address, please provide it here: _____

☐ **Fax** - Please provide your preferred fax number: _____

History

Sex assigned at birth: ☐ F ☐ M ☐ Intersex

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

☐ No medical or surgical treatments

- ☐ Hormone replacement therapy (HRT), currently using - Estimated start date: _____
- ☐ Hormone replacement therapy (HRT), no longer using - Estimated end date: _____
- ☐ Breast augmentation
- ☐ Orchiectomy
- ☐ Penectomy
- ☐ Vaginoplasty, penile inversion
- ☐ Vaginoplasty, colon graft
- ☐ Tracheal shave (aka: reduction thyroid chondroplasty)
- ☐ Laryngeal feminization surgery
- ☐ Voice surgery
- ☐ Scalp advancement
- ☐ Forehead reconstruction
- ☐ Soft tissue filler injections
- ☐ Mastectomy (aka: total reduction mammoplasty)
- ☐ Hysterectomy
- ☐ Oophorectomy
- ☐ Salpingectomy
- ☐ Vaginectomy
- ☐ Phalloplasty
- ☐ Metoidioplasty
- ☐ Urethroplasty
- ☐ Scrotoplasty
- ☐ Other unlisted surgical procedure: _____

Are you currently working with a counselor/therapist? ☐ Yes ☐ No

If yes... Therapist's name: _____ Therapist's phone: _____

Is your therapist a gender therapist? ☐ Yes ☐ No

Insurance

Insurance Provider/Plan Name: _____

Is this a Medicaid plan? ☐ Yes ☐ No

If yes, is it a Medicaid plan from Michigan? ☐ Yes, Michigan ☐ No, Another State

Do you get your insurance from the University of Michigan? ☐ Yes ☐ No

More detailed information about your insurance plan will be needed later in this process. If your insurance plan changes, please let us know as soon as possible.

CGSP frequently receives requests from researchers around the country who are looking for participants for their research on transgender healthcare. This research aims to gather information to improve the quality and accessibility of care for transgender and gender diverse individuals.

If you are interested in receiving monthly emails regarding opportunities to participate in research, please check this box: ☐

Receiving the email updates in no way requires you to participate in the research opportunities and you will be able to opt out of receiving these emails at any time by contacting the CGSP office (phone: 734-998-2150, email: genderservices@med.umich.edu).

If there is any further information you would like to include, please use the space below.

Return completed forms to CGSP in one of the following ways.

Fax: 734-998-2152
Mail: Michigan Medicine - CGSP
4250 Plymouth Rd,
Ann Arbor, MI 48109
Email: genderservices@med.umich.edu

If you have any questions or concerns, please contact CGSP directly.

Phone: 734-998-2150
Email: genderservices@med.umich.edu