GENDER MEDICINE CENTER
Texas Children's Hospital
Baylor College of Medicine
Houston, Texas

REFERRAL FOR SPECIAL SERVICES
New Patient Referral Fax to 832-825-9068
Insurance Referrals May be Faxed to 832-825-3072
Phone 832-822-3670

PATIENT INFORMATION

Date of Referral _____

Patient's Name _____Date of Birth_____Gender_____

Address: _____City _____ State _____ Zip_____

Parent or Guardian's Name _____

Parent/Guardian's Telephone: 1.)_____2.) _____

Translator needed? Yes / No If Yes, what language?_____

DIAGNOSIS FOR REFERRAL

__ Congenital adrenal hyperplasia
__ Gonadal dysgenesis
__ Androgen insensitivity
__ Klinefelter syndrome
__ Female with virilization
__ Male with undervirilization
__ Male with micropenis
__ Male with undescended testes
__ Male with Significant Hypospadias
__ Infant born with ambiguous genitalia
__ Vanishing testis syndrome
__ Amenorrhea in female older than 14 years of age
__ Other genetic syndromes with unusual, sexual differentiation findings
__ Turner syndrome with DSD
__ Other Disorder of Sexual differentiation

REQUESTING PHYSICIAN OR GROUP

Requesting Physician's Name _____

Primary Care Physician's Name (if different)_____

Office/Institution Name _____

Address: _____City _____ State _____

Referring Physician's Telephone Number_____

Signature of Referring Physician_____