Dr. Bert Oelbrandt
Plastic Surgeon
2pass Clinic, Ringlaan 51, 2600 Berchem, Belgium
Belg. RIZIV nr.: 1-09520-90-210
ISAPS certified plastic surgeon (4281 - http://www.isaps.org/find-a-surgeon/profile/4281/)

FFS CONSULTATION FORM: Date: _____/_____/_____

Surname: _____ First name: _____

Chosen name: _____

Date of birth: _____/_____/_____ Gender: male / female / other: _____

Address: _____City: _____

Postal code: _____ Country: _____

Mobile phone number: _____

Email address: _____

Transgender team:_____

General practitioner:_____

Psychologist:_____

Profession: _____

Single/partner/married

Procedure of interest: _____

Since how long do you consider this procedure? _____

Social:

- When approximately did you decide that you wanted to transition? _____
- Did you already start with facial hair removal? YES/NO When? _____
- When did you start wearing female clothes? _____
- Did you already start hormone therapy (estrogens, anti-test, …)? YES/NO When? _____
- Do you have children? YES/NO
- Do you have siblings and are they accepting and supportive? YES/NO
- Are your parents accepting and supportive? YES/NO
- Living alone or together with partner/parents/spouse? _____
- Do you have supportive friends? YES/NO
- Which sport do you practice and how many times per week? _____
- What are your hobbies? _____

May we contact your family doctor? YES/NO

Is your doctor supportive? YES/NO

Has your appearance often gotten in the way of doing things with friends, your family or dating? YES/NO

Has your appearance caused you any problems with school or work? YES/NO

Signature patient:

Are there things you avoid because of how you look? YES/NO

Do you consider it important what other people think of you (looking for reassurance)? YES/NO

How many hours per day are you looking in the mirror? _____ Do you avoid the mirror? YES/NO

Have you already consulted a psychologist, a psychiatrist or a transgender team previously? YES/NO

Have you ever been depressed or did you ever take antidepressants? YES/NO

PASSABILITY SURVEY

Do you live fulltime as a woman at this moment? YES/NO

How often are people doubting your gender?

- Couple of times a day/About once a day/About 3 to 6 times a week/About once to twice a week
- Few times a month/About once a month
- Never

How would you grade your passability at this moment?

- Very bad/bad/rather bad/rather good/good/very good

How much make-up you need to be able to pass?

- None/light/medium/heavy make-up

What do you think is the main cause for people to doubt your gender:

- Your face
- Your voice
- Your body

Do you smoke? YES/NO How many cigarettes a day? _____

Do you drink alcohol? YES/NO How many glasses a week? _____

Do you bruise easily? YES/NO

Allergies (e.g. Latex, penicillin, pollen, hay fever, fruits, peanuts) _____

Medication (HRT, inhalers, nicotine patches or chewing gum, drugs, cocaine, homeopathy, vit C, E, Ginseng, Gingko Biloba,…) _____

_____

Family history for: breast cancer, blood clots, bleeding, heart disease, anything else? _____

Do you suffer from any of the following?

Heart condition, blood pressure, diabetes type I / II , anemia, sickle Cell, asthma, embolism, kidney condition, skin condition (acne, …), blood clots in legs/lungs/elsewhere, zoster, weight loss, blood loss in stools/urine, thyroid disorder, infection (sinusitis, bladder, hepatitis, HIV, herpes, cold sores, tooth, throat), weight loss, eye condition (glaucoma, dry eyes, lazy eye), brain condition (head ache, depression, epilepsy), joint/back/neck (pain, arthritis), tooth decay, pain in the chest/arms/legs, facial pain, easy bruising, short of breath, … YES/NO _____

Approximate date of your last eye check:_____ Normal eye pressure? YES/NO

Approximate date of your last dental check:_____

Approximate date of your last blood check:_____

Any crowns, implants, root canal treatment, wisdom teeth removal? _____

Have you already had a consultation with another clinic or surgeon regarding this procedure? YES/NO

Previous surgical/cosmetic procedures (please advise of any problems with local/general anesthetic and list all cosmetic surgery?)

_____

_____

The limitations, complications and alternatives of the procedure will be discussed during the consultation.
For most procedures we recommend a second consultation, free of charge.
We encourage patients to discuss their intentions with their family doctor, close family and psychologist.

Signature patient: