Government of Newfoundland and Labrador
Department of Health and Community Services
Medical Services Division
mcp

Transition-Related Surgery
Request for Prior Approval

Patient Information Sheet
To be completed by the patient.

Name (as it appears on your MCP Card): _____

Name to be used for correspondence: _____
(If different from that which appears on your MCP card)

MCP Number: _____ MCP Expiry Date: _____

Address: _____

_____ Postal Code: _____

Phone Number: _____ Date of Birth (y/m/d):_____ Age:_____

Complete Patient Declaration

- A health care professional has explained the risks and complications associated with the proposed TRS procedure. **Yes / No**

- I understand that MCP covers the insured TRS procedures listed in Appendix B (List of Insured Transition-Related Surgeries) when they are provided within Canada at publically funded facilities. When insured TRS procedures are not available within Canada at publically funded facilities, prior approval may be granted for procedures performed at an approved private facility in Canada. **Yes / No**

- I understand there is no MCP funding for:
  - TRS services received without prior approval from MCP. **Yes / No**
  - TRS procedures not listed in Appendix B including facial feminization, liposuction, tracheal shave, voice pitch surgery and cosmetic surgical revisions. **Yes / No**
  - Any services which are not insured by MCP. **Yes / No**

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Patient - Certification and consent

- I understand that I am personally responsible for the payment of any services which are not insured by MCP.
- I certify that the information given on this form is complete and accurate.
- I understand that my personal health information collected on this form and the attached supporting documents will only be used to process my request and will not be disclosed without my consent unless required by law.

Name (please print):_____

Signature: _____ Date: _____