FENWAY HEALTH

Thank you for scheduling a medical appointment in the Trans Youth Clinic! You are receiving this packet to help prepare for your child's first few visits with Fenway Health.

We ask that your child be accompanied by at least one parent or guardian who can consent to treatment during the first visit. All legal guardians are required to consent to the use of puberty suppression and/or hormone therapy. We can address questions about custody agreements or extenuating circumstances during a future appointment.

We ask for information about your child's medical and behavioral health history and their current care team in this packet to learn about your child's individual needs and help with care planning. We will work with you to gather any information that you are unable to bring to the first visit.

Prior to your child's first appointment with a medical provider, we invite you to attend our Youth and Family Orientation Night on the 2nd Tuesday of each month from 6:30-8PM. This is an evening for families of trans and gender diverse youth to meet members of our trans youth care team, learn about the comprehensive services offered and what to expect from care. Topics covered in this session include the process of getting started with gender affirming medical care, puberty blockers, hormone therapy, behavioral health support, insurance, prior authorizations, and non-medical aspects of gender affirmation surrounding care for trans and gender diverse youth.

The Zoom link for this meeting is available on our website: https://fenwayhealth.org/transyouth.

Gender affirming medical care for youth at Fenway Health covers a number of topics over the course of several appointments. In addition to in person visits, we also offer telehealth appointments as long as you and your child are physically located in Massachusetts at the time of the appointment. Our model of care allows time for you, your child, and family to meet your child's provider and care team, talk about your child's goals for gender affirmation, discuss their health history, ask questions and share information, and come up with a treatment plan that works for everyone. Our medical team will conduct an in person physical, usually during the second visit, to get a sense of your child's developmental stage. We may also order lab tests during this visit too.

We will also work with you and your child to ensure that a Youth Gender Affirming Care Behavioral Health Assessment is completed by your child's therapist. If your child already has a therapist that they talk to about their gender and that therapist is comfortable doing the assessment, we'll get in touch with them to coordinate this. If your child needs a therapist for this assessment, our behavioral health team will work with you to get that scheduled. The purpose of the Behavioral Health Assessment is to clarify goals for gender affirmation, including the use of puberty blockers and/or hormone therapy, and support you and your child through the initial steps.

Once you and your child have completed these steps and want to move forward with gender affirming medical treatment such as puberty blockers or hormone therapy, we'll spend time reviewing consent forms, talking about prescriptions, dosing, lab monitoring, and ongoing appointments.

Your child's care team is available to provide support and resources to you as needed and on an ongoing basis.

RESOURCES AND SUPPORT

Fenway Health offers a parent drop-in group on the 1st Thursday evening of each month from 7-8:30PM by Zoom. This group provides a place for parents/guardians of any age gender diverse child to ask a medical provider and licensed mental health professional questions. The Zoom link is available on our website: https://fenwayhealth.org/transyouth.

Peer community support for parents – The Greater Boston PFLAG can connect parents to peer groups around the greater Boston area. https://gbpflag.org.

Supports for youth ages 22 and under, including mental health services, are available at Boston Alliance of Lesbian, Gay, Bisexual, Transgender, and Queer Youth, Inc. (BAGLY). They hold weekly meetings and drop-in programs. For more information visit https://bagly.org.

Support for families may be available through the services of SAYFTEE https://sayftee.com, a youth and family educational and empowerment support organization.

Boston GLASS (Gay and Lesbian, Bisexual and Transgender Adolescent Social Services) provides a continuum of services, including mental health services to youth of color (ages 13-25) in the greater Boston area. Find more information on https://jri.org/services/health-and-housing/health/boston-glass.

TGNC-kids Listserv - Email list with Boston area parents of trans/gender diverse youth asking for advice, hosting gatherings, etc. Email transyouth@fenwayhealth.org to get added.

Transgender Care Listings is a database to locate gender affirming providers in your state: http://transcaresite.org.

For further resources and information check or contact the following: https://tinyurl.com/transyouthvirtualsupport.

CONTACT INFORMATION

Trans Youth & Family Coordinator
transyouth@fenwayhealth.org
617-356-1573

Medical Appointments
617-457-8140

Clinical Questions and Advice
617-927-6300

Behavioral Health & Substance Use Services
617-927-6202

Pharmacy and Refills
617-927-6163

Billing Department
617-927-6050

Referrals
617-927-6130
Fax: 617-425-5730
rcoordinators@fenwayhealth.org

Medical Records
Fax: 617-425-5713
medicalrecords@fenwayhealth.org

Violence Recovery Program
800-834-3242

Quest Labs
866-697-8378

For urgent issues after hours, call our main number
617-267-0900

DIRECTIONS AND PARKING

Appointments at 1340 Boylston Street: The 1340 Fenway Health clinic is located at 1340 Boylston Street, Boston, MA 02215. This clinic is nearby Fenway Park. Red Sox games disrupt parking and traffic patterns during and for two hours before and after any home games. Please plan travel with this in mind. There is limited metered parking on Boylston Street. Public parking lots are available underneath the building (entrance is on Jersey Street under 1330 Boylston Street), under the City Target building (entrance on Richard B. Ross Way), and under the Trilogy Building (entrance on Kilmarnock Street). All parking lots charge by the hour. During home games, all lots charge a flat fee of $40 or higher starting two-hours before the game's start time. The closest MBTA train and bus stops include the D- Riverside Green Line 'Fenway' Station stop, the C, D, and B lines Kenmore Station stop, and the #55 Bus Boylston Street & Jersey Street stops. Train stops are at least a 15-minute walk from the clinic. Plan your route and timing of bus and train services in advance.
Main number: 617-267-0900
Appointments line: 617-927-6000

Appointments at 142 Berkeley Street: The Fenway: South End clinic is located at 142 Berkeley Street, Second Floor, Boston, MA 02116, at the corner of Columbus Avenue and Berkeley Street. This clinic is a couple blocks from the back of the MBTA Back Bay Station on the Orange Line and Commuter Rail. The entrance of the building is near the Mitchell Gold + Bob Williams store. There is a parking garage located around the corner on Clarendon Street, as well as metered parking on Columbus Avenue or Berkeley Street. The #9 Bus has a stop across the street at Berkeley Street & Columbus Avenue.
Main number: 617-247-7555
Appointments line: 617-927-6000

TRANS YOUTH CLINIC MEDICAL INTAKE APPOINTMENT

Please bring in or be prepared to discuss the following information for your child.

MEDICAL INFORMATION

Name, address, and phone number for your child's primary care provider/pediatrician

Provider Name	
Phone Number	
Address	
City, State, Zip	

Complete one Disclosure of Protected Health Information form (attached) for this provider

List any medications prescribed by this provider

Medication Name	Dose and How Often Taken	Reason For Medication

Please write any additional medications on another page or bring in a list from the provider's office. Bring in a list or be prepared to discuss any current medical conditions, and be prepared to discuss history of childhood illnesses, accidents, hospitalizations, vaccines, allergies, etc.

INSURANCE INFORMATION

Some medications require a prior authorization. Your child's medical team will need this additional insurance information to be able to submit it.

Child's Name on Insurance	
Gender Marker on Insurance	
Member ID Number	
BIN Rx	
Group Rx	
PCN	

BEHAVIORAL HEALTH INFORMATION

Name, address, and phone number for your child's psychiatrist if there is one.

Provider Name	
Phone Number	
Address	
City, State, Zip	

Complete one Disclosure of information form (attached) for this provider.

List of medications and dosages prescribed by this provider

Medication Name	Dose and How Often Taken	Reason for Medication

Please write any additional medications on another page or bring in a list from the provider's office. Bring in a list or be prepared to discuss diagnoses currently being treated by this provider.

Name, address, and phone number for your child's individual therapist

Provider Name	
Phone Number	
Address	
City, State, Zip	

Complete one Disclosure of information form (attached) for this provider.
Be prepared to discuss any hospitalizations, emergency department visits, or self- harming behaviors.

Name, address, and phone number for the family therapist and/or other provider(s)

Provider Name	
Phone Number	
Address	
City, State, Zip	

Complete one Disclosure of information form (attached) for this provider.

FAMILY STRUCTURE & GUARDIANSHIP

Who does this child live with?

Name	Relationship to Child

If the child lives outside the parent/guardian's home, provide contact details for the place of residence.

Residence Name	
Primary Contact	
Phone Number	
Address	
City, State, Zip	

Name(s) and contact information for all adults who have the legal right to consent or object to treatment.

	Guardian #1	Guardian #2
Name		
Relationship		
Phone Number		
Address		
City, State, Zip		

You must provide a copy of the court documentation assigning guardianship for medical decisions to anyone other than the biological parents of the child. (i.e., adoption, divorce, separation, etc.)

Fenway Health Authorization for Disclosure of Protected Health Information

1.) Patient Information

Patient Name: _____ Name used *(if different):* _____
Date of Birth _____ Address: _____
Phone Number: _____ Email address: _____
Preferred method for Medical Records dept. to contact you (*select one*): ☐ Phone ☐ Email

2.) I give permission to release my protected health information and medical records FROM:

Sender/ Facility's name: _____ Phone Number: _____
Address: _____ Fax Number: _____

3.) I give permission to release my protected health information and medical records TO:

Recipient/ Facility's name: _____ Phone Number: _____
Address: _____ Fax Number: _____

4.) Reason for Release: (Select all that apply)

☐ To allow bi-directional communication with service provider (***No records will be sent by medical records; Skip to Section 6)***
☐ Transfer **ALL** care to another provider
☐ Share medical records with another provider
☐ Legal Purposes
☐ Insurance Purposes
☐ Other (*please specify*) _____
_____

5.) The following information is to be disclosed: (Select all that apply)

☐ All Records
☐ Abstract (*includes 2 years of office visits, labs, immunizations, diagnostics & radiology reports)*
☐ Treatment received between dates _____ to _____
☐ Optometry Records
☐ Dental Records
☐ Other (*please specify*) _____
_____

6.) Sensitive Information

*Fenway Health **WILL NOT** disclose the following information without your signed authorization. Please initial next to each type of record you will like to be released:*

☐ I would **not** like sensitive information to be disclosed

- Abortion Care _____
- Alcohol/Substance Use Treatment _____
- Behavioral Health information written by medical provider _____
- Behavioral Health information written by psychiatrist, therapist, mental health clinician or social worker _____

COMPLETE THIS ENTIRE SECTION TO ENSURE NO DELAY IN PROCESSING

- Genetic Testing _____
- HIV/Aids Results or related care _____
- Intimate Partner Violence Counseling _____
- Sexually Transmitted Diseases _____
- Sexual Violence Counseling _____

7.) Signature

This authorization is valid for this request only and will not be honored for any subsequent requests. This authorization for disclosure (unless expressly revoked earlier) will remain valid for one year from the date signed below. I understand that I may revoke this authorization at any time by making a request in writing to the Privacy Officer of Fenway Health. I understand that substance abuse records are protected by 42 CFR, Part 2 and may not be disclosed without my specific authorizations. Those same federal regulations also protect any substance abuse records from re-disclosure by any third party. I hereby acknowledge that I have read, or have had read to me, and fully understand the above statements as they apply to me, and do voluntarily consent to disclosure.

X _____
Patient's signature or authorized agent's signature (please specify relationship to patient) Date

Mail/Fax to: Fenway Health
Attn: Medical Records Dept
1340 Boylston St. Boston, MA 02215

Phone: 617-927-6191
Fax: 617-425-5713
Email address: medicalrecords@fenwayhealth.org

Updated January 2021