**Date of Letter:** MM/DD/YYYY*Note: this is the date the letter is finalized*

**Client/Patient Demographics**

Name:Client Name

Legal name if different:Client’s Legal Name

Pronouns:Pronoun 1/Pronoun 2

DOB:MM/DD/YYYY

**Phone:** (###)###-####

**Address:** Client’s Address

**Clinician Information**

Clinician Name:Name

Office/Agency location or clinic: Location or Clinic

Phone number of clinician:(###)###-####

Clinician email address:clinician@clinic.com

Type of license: *Name of License Held*

***Note: Assessments must be completed or attested to by a licensed clinician.***

Please describe your experience completing assessments for gender affirming surgeries:

Description of experience

**For which surgery/surgeries does this letter of support endorse?** *Check* ***ALL*** *that apply*

[ ]  Breast augmentation

[ ]  Mastectomy with chest reconstruction

[ ]  Orchiectomy

[ ]  Hysterectomy/Oophorectomy

[ ]  Vaginoplasty/Vulvoplasty

[ ]  Vaginectomy

[ ]  Metoidioplasty

[ ]  Phalloplasty

[ ]  Facial gender confirmation

[ ]  Tracheal Shave

[ ]  A surgery not listed here. Please describe: description of surgery

Please list the dates that you met with this client to complete this assessment/letter of support for gender affirming surgery:
MM/DD/YYYY

Please give a description of this client, identifying characteristics, age, ethnicity, language, gender identity, etc., and their history of gender dysphoria and emphasize their attempts to address their gender dysphoria.

Click or tap here to enter text

Does you client meet criteria for diagnosis of Gender Dysphoria, per DSM-5?

|  |  |
| --- | --- |
| [ ]  Yes | [ ]  No |

If your client is taking gender affirming hormone therapy, please indicate the length of time your client has taken hormones. How do they describe their response to hormones? (e.g., decreased dysphoria, could not tolerate them, etc.)

Click or tap here to enter text.

Please describe your rationale for the referral for surgery at this time:

Click or tap here to enter text.

Are there challenges the surgeon(s) and care team need to know about regarding communication? These could include English fluency, hearing impairments, autism spectrum, literacy level, learning differences, etc.:

Click or tap here to enter text.

For *each* surgery your client is requesting, please describe how each surgery will improve your client's functioning. How will it make their life better? ***Please use the client's words***:

Click or tap here to enter text.

If client is referred for facial gender confirmation, please specify any concurrent mental health diagnoses, symptoms, and how dysphoria related to their facial features affects their daily life. Please include what mental health care attempts have been made to remedy facial dysphoria. ***Please use client’s words and be very specific***:

Click or tap here to enter text.

Describe how your client has approached educating themselves about the surgery/surgeries they are seeking (e.g., spoke with peers, reviewed patient education booklets, internet research, prior consult with a surgeon, explanation by PCP, etc.):

Click or tap here to enter text.

Does your client have a mental health diagnosis or history that the stress of surgery, anesthesia, or recovery that may cause your client to have an exacerbation of symptoms or become destabilized? For instance: PTSD, anxiety disorders, depression, bipolar disorder, schizophrenia, substance abuse, etc. If yes, please describe how you have prepared your client for this possibility and how this will be addressed:.:

Click or tap here to enter text.

Please list all medications that the client is currently taking related to psychological concerns, sleep, or emotional problems (this should include supplements, like St. John's Wort and medical marijuana). *Please list the prescriber’s name next to the medication.*
List all medications

Please describe current and past substance use, including nicotine. Please list any concerns you or the client has regarding their substance use or their sobriety and any implications of using pain medication:

Click or tap here to enter text.

Substance use can cause problems related to anesthesia and pain control. If the patient substance use is a concern, what is the plan to reduce or stop substance use (including alcohol) before surgery? Do you believe the plan is realistic? What services were they offered to assist them?

Click or tap here to enter text

Nicotine can cause some surgeries to be canceled. What is your client’s plan to stop nicotine use prior to surgery? Do you believe the plan is realistic? What services were they offered to assist them?

Click or tap here to enter text.

Please describe your client’s plan for housing following surgery. Will they be staying in their own home or recovering elsewhere? Does this recovery environment include access to a clean and private bathroom? Does the recovery environment have stairs to access the living space or stairs within the living space that could create barriers to recovery?

Click or tap here to enter text.

Describe your client's support system (relationships, family support, etc). Who will help the patient during their recovery and how long will they be available in person following hospital discharge?

Click or tap here to enter text.

Do you believe your client is capable of carrying out their aftercare plan, (including providing for their own self-care following surgery (e.g., dilation 3x per day, wound care, proper hygiene, reduced activity, monitoring for infection, getting adequate nutrition, staying housed, paying bills, etc.)?

|  |  |
| --- | --- |
| [ ]  Yes | [ ]  No |

Some health plans impose an expiration date on Letters of Support. What plans have you and your client established to update this letter in the case that this letter is deemed expired prior to the date of surgery?

Details of plan

What additional care might your client need and how will that be arranged?

Additional care

**Does your client demonstrate capacity to provide informed consent? If no, please comment in the space provided below.**

|  |  |
| --- | --- |
| ☐ Yes ☐ No |  |
| If no, please provide comments |  |

**Please indicate by checking each box below that you discussed these issues to you and your client's satisfaction:**

Potential alterations in sexual functioning
[ ]  Risks and benefits of surgery and alternatives to surgery
[ ]  The impact of smoking, drugs, and alcohol on surgery and surgical outcomes
[ ]  The experience and impact of pain physically and/or emotionally
[ ]  The importance of aftercare related to post-operative complications and aesthetic outcomes
[ ]  Limits to fertility and reproduction (Hysterectomy, oophorectomy, orchiectomy, and genital surgeries only)

**Do you believe your client has realistic expectations regarding surgery as far as:**

|  |  |  |  |
| --- | --- | --- | --- |
| Aesthetic outcome of surgery and impact on dysphoria? | [ ]  Yes | [ ]  No |  |
| Functional outcome following surgery? | [ ]  Yes | [ ]  No |  |
| Potential for complications? | [ ]  Yes | [ ]  No |  |
| Level of support needed during recovery? | [ ]  Yes | [ ]  No |  |
| Ability to cope with surgical complication? | [ ]  Yes | [ ]  No |  |
| Erotic sensation and sexual function? | [ ]  Yes | [ ]  No | [ ]  N/A |
|  |  |  |  |

**I am available to participate in care coordination if/as needed by the surgical team.**

|  |  |
| --- | --- |
| [ ]  Yes | [ ]  No, I will provide referrals |

**My perferred method of communication is:**

|  |  |  |
| --- | --- | --- |
| [ ]  Email | [ ]  Phone | [ ]  Either |

**Is there anything you would like to add?**

Additional Information

Your name, title and license: Name, title, license

Your signature:

Supervisor name, title and license:Name, title, license
**Attestation: I have reviewed the assessment and concur with the recommendations as stated.**

Supervisor signature (if applicable):