

Medical Letter of Support – Transfeminine

Date:
Patient Name:
Date of Birth:

To whom it may concern,

 Patient Name has been a patient at Clinic Name since Month/Year . She is a transgender woman, who has lived in the gender role that corresponds with her gender identity since Month/Year and I am writing this letter in support of Patient Name undergoing the _____ procedure.

If the patient is seeking breast augmentation, please include the following paragraph:

 Patient Name **has been on feminizing hormone therapy for an excess of 24 months. This treatment has not been effective in providing the patient with sufficient breast growth for a feminine physique. This patient requires surgical intervention to help alleviate her continued dysphoria related to this physical characteristic.**

 Patient Name experiences persistent gender dysphoria (gender identity disorder, ICD-10 F64.0), and this medically necessary gender-confirming surgery is the next step in her transition process. In order to receive gender-affirming treatment at Surgical Facility Name , Patient Name was determined to have capacity to make informed consent. This is appropriate treatment in accordance with the guidelines from the World Professional Association of Transgender Health SOC ver 7.

 Patient Name initiated hormone therapy in Month/Year .
 Patient Name transferred hormone replacement therapy to my care on Month/Year ; include if applicable. Her current medical regimen includes Insert regimen which she has been taking since Month/Year .

 Patient Name has no significant medical diagnoses that could increase intra- or post-operative complications.

Given this, Patient Name is recommended for surgery.

Writer's Name and Credentials

License
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**Medical Letter template adapted from our colleagues at Callen-Lorde Community Health Center*