Medical Letter of Support – Transmasculine

Date:
Patient Name:
Date of Birth:

To whom it may concern,

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

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 his 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.* His current medical regimen includes *Insert regimen* which he 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
NPI
Address
Contact Phone

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