<u>Mental Health Letter of Support – Transfeminine Procedures</u>

Date Seen:
Patient Name:
Date of Birth:

To whom it may concern,

It is my pleasure to write this letter on behalf of ____*Patient Name*____, DOB___ who was evaluated on the above date for psychiatric clearance prior to **vaginoplasty/orchiectomy/chondrolaryngoplasty/glottoplasty/breast surgery/facial feminization surgeries.**

Diagnosis of Gender Dysphoria

____*Patient Name*____ meets criteria for Gender Dysphoria in Adolescents and Adults (F64.1) as evidenced by:

- Marked incongruence between experienced/expressed gender and assigned gender which she has experienced since her childhood.
- Notable evidence of a strong desire to rid of her primary/secondary sexual characteristics.
- Strong desires for primary/secondary sex characteristic of the other gender.
- Strong desire to be treated as the other gender.
- Strong desire to be of the other gender.
- The condition has been known to cause clinically significant distress in her social life, interpersonal relationships and employment

____*Patient Name*____ reports realizing her gender identity as female from age __________. She came out as transgender at age _________ and socially transitioned at _______. She began hormone therapy at age___. *<u>List other gender affirming surgeries/procedures,</u> if applicable*. She has taken steps to have her name and gender marker changed on legal documents, *if applicable*.

If the patient is seeking FFS, please include paragraph below; or a statement of which facial features cause dysphoria and which more conservative measures (makeup, hairstyle, etc) they have taken to lessen the dysphoria which have not helped.

It is evident that ____*Patient Name*____ has struggled with worsening dysphoric feelings throughout her life, experienced as anxious and depressive symptoms, and has only received partial relief since starting her transition. Due to her male facial characteristic including square and angulated features, receded hairline, prominent thyroid and nasal cartilage and lack of female facial characteristic such as less pronounced mandibular angles, full lips, less nasal prominence or pronounced zygomatic processes, she continues to experience significant dysphoric symptoms. The presence of secondary male sex characteristics (e.g. testes and penis, masculine facial features) and lack of secondary female sex characteristic (e.g. breasts,) have all been a source dysphoric feelings that at times during patients life have interfered with her ability to function. **Include above specifics or other examples of incapacitating features as applicable to the patient.**

Include brief mental health history, including current psychiatric (non-hormone) medications with and doses, active psychiatric symptoms that may impair surgical recovery (psychosis, mania, intellectual disability severe

depression or anxiety, etc), active substance use, history of suicide attempts, self-harm and psychiatric hospitalizations. Template for negative exam below, if applicable.

____*Patient Name*____ reports no mental health history outside of gender dysphoria. She has no history of suicide attempt or psychiatric hospitalization; she does not take nor require psychotropic medications at this time. She has no psychiatric symptoms that impair her ability to make informed medical decisions or impact her gender identity.

Capacity Assessment

____*Patient Name*____ comprehends the basic procedure, risks, benefits and potential complications of **vaginoplasty/orchiectomy/chondrolaryngoplasty/glottoplasty/breast surgery/facial feminization surgeries.** She is able to verbalize a clear decision and weigh the risk and benefits of undergoing these surgeries **including sterility, need for dilation** and possibility of **colon perforation, rectovaginal fistula,** bleeding, scarring, infection or poor outcome. It is my clinical assessment that ____*Patient Name*____has the capacity to consent to these surgical procedures.

Statement of Medical Necessity

I completely support ____*Patient Name*____desire for **vaginoplasty/orchiectomy/chondrolaryngoplasty/glottoplasty/breast surgery/facial feminization surgeries** and determine that that this procedure is of medical necessity to treat underlying gender dysphoria.

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Contact Phone