Mental Health Letter of Support – Transmasculine Procedures

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 **chest masculinization surgery/hysterectomy/metoidioplasty/phalloplasty** 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 he has experienced since his childhood.
- Notable evidence of a strong desire to rid of his 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 his social life, interpersonal relationships and employment

____*Patient Name*____ reports realizing his gender identity as male from age ________. He came out as transgender at age ________ and socially transitioned at ________. He began hormone therapy at ___. *List other gender affirming surgeries/procedures*, *if applicable*. He has taken steps to have his name and gender marker changed on legal documents, *if applicable*.

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*____ has no mental health history outside of gender dysphoria. He has no history of suicide attempts or psychiatric hospitalizations and takes nor requires psychiatric medications. He has no psychiatric symptoms that impair his ability to make informed medical decisions or impact his gender identity.

Capacity Assessment

____*Patient Name*____comprehends the risks, benefits and potential side effects of **chest masculinization surgery/hysterectomy/metoidioplasty/phalloplasty**. He is able to verbalize a clear decision and weight the risk and benefits of undergoing these surgeries including **sterility, urinary fistula or stricture, graft necrosis/rejection,** bleeding, scarring, infection and possibility of a 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 **chest masculinization surgery/hysterectomy/metoidioplasty/phalloplasty** and determine that that this procedure is of medical necessity to treat underlying gender dysphoria.

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Writer's Name and Credentials
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