HPI transfeminine

Name: ***
Pronouns: ***
Gender identity: ***
Sex recorded at birth: ***

When did you first realize your gender identity did not align with the sex assigned at birth? ***
How has your social transition been? ***
Plans for name/gender marker change? ***

What are your ultimate goals for hormonal transition? ***
What are your ultimate goals for surgical transition? ***

Started gender-affirming hormones/what types and routes of administration: ***
Previous prescribing provider(s): ***

Current hormonal regimen, if applicable: ***
Any desired effects yet? ***
Any adverse reactions? If yes, which ones?: ***

Feminizing effects (per patient):
Redistribution of body fat ***
Decrease in muscle mass and strength ***
Softening of skin/decreased oiliness ***
Decreased sexual desire ***
Decreased spontaneous erections ***
Breast growth ***
Smaller/softer testes ***
Decreased terminal hair growth ***
Voice change ***

Current mental health provider: ***
Other medical providers (e.g., PCP, ob/gyn, plastics): ***

Past medical history: ***

Feminizing tx:
VTE or blood clotting disorder ***
Migraines (w/ aura?) ***
Hyperprolactinemia/prolactinoma ***
Breast cancer ***
CAD ***
Stroke ***
Cholelithiasis ***
Hypertriglyceridemia ***
Fractures ***

Fertility desire/Any prior egg/sperm preservation: ***
Age-appropriate cancer screenings: ***

Surgical history: ***
Family history: ***
Military history: ***

Social/family support: ***

School/Work: ***

Alcohol: ***
Tobacco: ***
Marijuana: ***
Other drugs: ***

Sexual orientation/preference: ***
Sexual behaviors/safe sex practices: ***

HPI transcmasculine

Name: ***
Pronouns: ***
Gender identity: ***
Sex recorded at birth: ***

When did you first realize your gender identity did not align with the sex assigned at birth? ***
How has your social transition been? ***
Plans for name/gender marker change? ***

What are your ultimate goals for hormonal transition? ***
What are your ultimate goals for surgical transition? ***

Started gender-affirming hormones/what types and routes of administration: ***
Previous prescribing provider(s): ***

Current hormonal regimen, if applicable: ***
Any desired effects yet? ***
Any adverse reactions? If yes, which ones?: ***

Masculinizing effects (per patient):
Skin oiliness/acne ***
Facial/body hair growth ***
Increased muscle mass/strength ***
Fat redistribution ***
Cessation of menses ***
Clitoral enlargement ***
Vaginal dryness/atrophy ***
Deepening of voice ***

Current mental health provider: ***
Other medical providers (e.g., PCP, ob/gyn, plastics): ***

Past medical history: ***

Masculinizing tx:
Erythrocytosis hct >50% ***
OSA ***
Transaminitits ***
CAD ***
Stroke ***
HTN ***
Breast/endometrial cancer ***

Fertility desire/Any prior egg/sperm preservation: ***
Age-appropriate cancer screenings: ***

Surgical history: ***
Family history: ***
Military history: ***

Social/family support: ***
School/Work: ***

Alcohol: ***
Tobacco: ***
Marijuana: ***
Other drugs: ***

Sexual orientation/preference: ***
Sexual behaviors/safe sex practices: ***

Plan: gender affirming hormone therapy start:

Gender dysphoria, initiation of * gender-affirming hormone therapy (GAHT):** Name: ***. Pronouns used: ***. Gender identity: ***. Sex recorded at birth: ***. *** (Relevant history).

In accordance to the Endocrine Society Clinical Practice Guideline for the endocrine treatment of gender-dysphoric/gender-incongruent persons (2017) and the World Professional Association for Transgender Health, Standards of Care v7 (2011), criteria have been met for gender-affirming hormone therapy initiation with ***: Persistent, well-documented gender dysphoria is present; *** has the capacity to make a fully informed decision and to consent for treatment; *** is of the age of majority; and there are no present uncontrolled medical or mental health concerns. Today, we discussed the risks and benefits of starting ***. We discussed a patient education sheet including expected effects, benefits, adverse reactions, and alternatives that will be uploaded into the media tab.

After discussing routes of administration, *** would like to start with ***.

Letter for gender affirming surgery for insurance

I am the physician providing gender-affirming hormone therapy for *** (Name used: ***; pronouns used: ***). *** has persistent gender dysphoria (ICD 10: F64.0), which has also been well-documented by *** mental health provider and by me. *** has been receiving gender-affirming hormone therapy since ***. *** has been under my care since ***, with last clinic visit on ***.

*** has the following medical conditions: ***
*** has the following psychiatric conditions: ***

All of these conditions are well controlled at this time.

I attest that gender-affirming surgery is medically necessary for ***. *** possesses the capacity to make a fully informed decision and to consent to treatment for gender-affirming surgery.

I am available for coordination of care and welcome a phone call or e-mail to establish this as needed.

@SIGNATURE@

CO Medical License: ***