Transgender Sex Reassignment Surgery Services
Medical Evaluation Form

Instructions: Please mark either "yes" or "no" for every item. All items must be completed.

Yes	No	
☐	☐	This patient has gender dysphoria

Hormone Therapy History *(Mark only one "yes"; the other three should be "no")*

Yes	No	
☐	☐	This patient has taken 12 continuous months of hormone therapy as appropriate to the patient's gender goals
☐	☐	Hormone therapy is not appropriate for this patient's gender goals
☐	☐	This patient has medical contraindications to hormone therapy
☐	☐	This patient is unable or unwilling to take hormone therapy

Medical conditions that could interfere with expected outcomes of proposed surgery

Yes	No	
☐	☐	Uncontrolled diabetes
☐	☐	Active infection
☐	☐	Severe immunosuppression
☐	☐	Unstable cardiovascular disease
☐	☐	History of venous thromboembolism
☐	☐	History of poor wound healing
☐	☐	Obesity BMI:________
☐	☐	Other unstable medical conditions: _____________________
☐	☐	None

Other Conditions

Yes	No	
☐	☐	Cigarette or Cannabis smoker
☐	☐	Other significant substance use

If conditions present document plans to stabilize:

Yes	No	
☐	☐	Medical conditions are well controlled
☐	☐	This patient has been engaged in medical care within DPH affiliated clinics for >1 year and attends medical visits regularly
☐	☐	It is my opinion that the proposed surgery will benefit this patients health

Medical Provider Name	Signature	Date
______________________________	__________________________________	________________