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|  | **San Francisco Department of Public Health****Gender Health SF**955 Potrero AvenueBuilding 80, 8000NSan Francisco, CA 94110Telephone: (628) 206-7979genderhealthsf@sfdph.org [www.sfdph.org/genderhealthsf](http://www.sfdph.org/genderhealthsf) |

**Gender Assessment Form for Facial Hair Reduction**

***Please note:***

1. **Facial Hair Reduction is *not* a pre-requisite for Facial Feminization Surgery.**
2. **For patients actively seeking Facial Feminization Surgery, they should consult with their surgeon regarding facial hair reduction.**

**Client's name**: Click here to enter text.

**Legal name if different**: Click here to enter text.

**DOB**: Click here to enter text.

**Clinician name**: Click here to enter text.

**Office location or clinic**: Click here to enter text.

**Are you licensed?** [ ]  Yes [ ]  No

**Please describe your experience completing assessments for gender related surgeries**. Click here to enter text.

**How long have you known this client?** Click here to enter text.

**Please list the dates that you assessed this client for readiness and appropriateness for surgical intervention. If two people are signing the same letter, please list the dates you each assessed the client.** Click here to enter text.

**General and Gender Health**

1. **Please describe this client (identifying characteristics, age, ethnicity, language, gender identity, housing situation, etc.).** Click here to enter text.
2. **Please describe your client’s experience of gender, their history of gender dysphoria and how they have attempted to address their gender dysphoria.** Click here to enter text.
3. **Please indicate the length of time your client has taken hormones. How do they describe their response to hormones (decreased dysphoria, could not tolerate them, etc.)? If they have not taken hormones or no longer take them, please explain.** Click here to enter text.
4. **Describe the client’s capacity to give informed consent for facial hair reduction. If they lack capacity, please explain.** Click here to enter text.
5. **In attempt to provide the most effective education and preparation, please let us know about any issues we may need to know regarding communication. These could include English fluency, hearing impairments, autism spectrum, literacy level, learning differences, etc.** Click here to enter text.
6. **For each facial hair reduction, please describe how the procedure will improve your client's functioning. How will it improve their quality of life and health and decrease symptoms? Please include the client's words.** Click here to enter text.

**Psychiatric and Behavioral Health**

1. **Please give a brief description of your client's behavioral health history, including suicidality, homicidality, history of violence towards healthcare workers, any psychiatric hospitalizations and residential treatment for mental health or substance use.** Click here to enter text.
2. **Please list all current and past behavioral health diagnoses.** Click here to enter text.
3. **Please list all medications that the client is currently taking related to psychological concerns, sleep, or emotional problems, including herbal supplements like St. John's Wort and medical marijuana. These can affect anesthesia, bleeding and pain control. *Please include the prescriber next to the medication(s).*** Click here to enter text.

***For facial hair reduction, it is important for patients and their care team to understand the differences between laser and electrolysis and that treatment will occur over a span of several months with numerous sessions.***

***Please review these topics to the best of your ability to ensure that your patient will be able to successfully complete treatment.***

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| Reviewed | GHSF F/U? |  |
|[ ] [ ]  1. Laser vs. Electrolysis: Considerations of skin tone, hair color and hair type. Risks and benefits of the selected procedure and alternatives to the procedure
 |
|[ ] [ ]  1. Pain: Possible difficulties with pain and pain management options.
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|[ ] [ ]  1. Realistic expectations about what the procedure can and cannot do physically, emotionally, and spiritually.
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1. **Is there anything you would like to add?** Click here to enter text.

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***By signing this Assessment, I acknowledge that I am available for consultation and care coordination, as requested by Gender Health SF, the San Francisco Health Plan and Healthy SF.***

**Name, title and license:** Click here to enter text.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Phone number for follow up:** Click here to enter text.

**E-mail number for follow up:** Click here to enter text.

**Name, title and license:** Click here to enter text.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Phone number for follow up:** Click here to enter text.

**E-mail number for follow up:** Click here to enter text.

**Please sign, print and fax this to your client’s Primary Care Provider (*Not Gender Health SF*) so the PCP can review and submit a complete referral to San Francisco Health Plan.**