



Pre-Surgical Addendum Form

Client Name: [Click here to enter text.](#)

Legal name *if different*: [Click here to enter text.](#)

DOB: [Click here to enter text.](#)

Procedure: [Click here to enter text.](#)

By completing this Addendum, I acknowledge that I have thoroughly reviewed previous assessment(s) for this client:

Assessment date: [Click here to enter text.](#)

Assessment author: [Click here to enter text.](#)

Assessment date: [Click here to enter text.](#)

Assessment author: [Click here to enter text.](#)

Please address significant changes from previous assessment(s), including:

Psychiatric and mental health: [Click here to enter text.](#)

Medical health: [Click here to enter text.](#)

Substance use, including nicotine and smoking any products: [Click here to enter text.](#)

Housing: [Click here to enter text.](#)

Support system, including care team: [Click here to enter text.](#)

Not listed: [Click here to enter text.](#)

For each surgery your client is requesting, please describe how *each* surgery will improve your client's functioning. How will it improve their quality of life and their health, and decrease symptoms? Please include the client's words.

[Click here to enter text.](#)

Many gender procedures have high complications risks, including unexpected emotional and social consequences related to surgery, medical or psychiatric decompensation, and patient dissatisfaction. It is important for mental health providers to be well informed to obtain informed consent and offer post-operative clinical support and coordination.

Please review these topics to the best of your ability to ensure that surgical intervention is the most appropriate treatment for your client's gender dysphoria and consult with the client's Primary Care Provider as needed.

Reviewed GHSF F/U?

1. Risks and benefits of surgery and alternatives to surgery.

2. Potential alterations in sexual functioning.

3. Sterilization and reproductive choices.

GHSF Pre-Surgical Addendum - 1



- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Impacts of smoking, drugs, and alcohol on surgery and surgical outcomes. |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Importance of aftercare related to post-operative complications and aesthetic outcomes. |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Realistic expectations about what surgery can and cannot do physically, emotionally, and spiritually. |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Realistic expectations about recovery and post-operative care. |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Mandatory GHSF Education, Preparation and Planning (EPP) program for genital surgery. |

9. Is there anything you would like to add? [Click here to enter text.](#)

BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I AM AVAILABLE FOR CONSULTATION AND CARE COORDINATION, AS REQUIRED BY GENDER HEALTH SF, THE SAN FRANCISCO HEALTH PLAN, AND HEALTHY SF.

NAME, TITLE, LICENSE:

Signature:

Date:

Phone number for follow up:

E-mail number for follow up:

NAME, TITLE, LICENSE:

Signature:

Date:

Phone number for follow up:

E-mail number for follow up:

Please sign, print and fax this to your client's PCP so the PCP can review and submit a complete referral to Gender Health SF.

If Gender Health SF is completing the Second Pre-Surgical Assessment, please sign, print, and fax this to Gender Health SF at (628) 206-7999.