Gender Pre-Surgical Assessment Form

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 and procedures. 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.

This is a:
☐ Single assessment or First assessment
☐ Second assessment

For which surgeries are you referring your client?

Bottom Surgeries	Top Surgeries
☐ Gender-Affirming Body Shaping ☐ Orchiectomy ☐ Hysterectomy / Oophorectomy ☐ Vulvoplasty / Labiaplasty ☐ Vaginoplasty ☐ Metoidioplasty ☐ Phalloplasty	☐ Gender-Affirming Facial Surgery ☐ Feminizing Mammoplasty (aka Breast Augmentation) ☐ Subcutaneous Mastectomy with Male Chest Reconstruction (aka Chest Surgery) **Non-Surgical Procedures** ☐ Facial Hair Reduction (electrolysis/laser) ☐ **Not listed. Please describe:** Click here to enter text.

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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. **For clients considering genital surgeries, WPATH Standards of Care states that the client must have "12 continuous months of living in a gender role that is congruent with their gender identity." Please describe how the client has met this standard.** Click here to enter text.

5. **Describe the client's capacity to give informed consent for surgery. If they lack capacity, please explain.** Click here to enter text.

6. **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.

7. **For each procedure your client is requesting, please describe how *each* 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

8. **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.

9. **Please list all current and past behavioral health diagnoses.** Click here to enter text.

10. **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.

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SURGERY PREPARATION AND AFTERCARE

11. **Which current or previous medical and/or mental health providers did you speak with in your evaluation? What were *their* thoughts about your client's readiness and eligibility for surgery?** Click here to enter text.

12. **Surgery can precipitate a relapse or decompensation. How can your client's mental health concerns be effected by the stress of surgery, anesthesia, or recovery?** Click here to enter text.

    Please describe how you have prepared your client for this possibility and your prevention and intervention plan. Click here to enter text.

13. **Smoking cigarettes or marijuana and use of nicotine in any form can cause surgery to be cancelled and increases complication risks. If your client currently or previously smoked cigarettes or marijuana, what was the *date* and *duration* of their last use?** Click here to enter text.

    What is your client's plan to reduce or stop smoking and nicotine use before surgery? Click here to enter text.

    Would you like more information on nicotine and smoking cessation resources?
    ☐ Yes ☐ No ☐ Not Applicable

14. **Substance use can cause problems related to anesthesia, bleeding and pain control. Please screen for substance use (the result of the CAGE, AUDIT or AUDIT-C is acceptable).** Click here to enter text.

    If the client currently or previously used substances, including alcohol, what was the *date* and *duration* of their last use? Click here to enter text.

    What is your client's plan to reduce or stop substance use before surgery? Click here to enter text.

15. **Describe any medical problems your client may have that may interfere with surgery, such as uncontrolled diabetes, sleep apnea, etc.** Click here to enter text.

    Have you consulted with their PCP to come up with a plan to manage these conditions?
    ☐ Yes ☐ No ☐ Not Applicable

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16. **What is your assessment of your client's functioning, including their ability to satisfactorily complete ADL's and IDL's?** Click here to enter text.

17. **Depending on the procedure and if there are any complications, time off work is recommended to be between 1 – 6 weeks, depending on the type of work. If your client is working, how will your client plan for this?** Click here to enter text.

18. **Please describe your client's housing situation. If they are seeking genital surgery, do they have a safe, private bathroom?** Click here to enter text.

19. **Describe your client's support system and relationships. Who will help with recovery?** Click here to enter text.

20. **Describe stressors that may interfere with your client's recovery, such as impending homelessness or living with unsupportive roommates.** Click here to enter text.

21. **Do you believe your client is capable of carrying out their aftercare plan, including providing for their own self-care following surgery (e.g. dilation 3x per day for Vaginoplasty, hygiene issues, monitoring for infection, getting adequate nutrition, staying housed, paying bills, etc.)? ☐ Yes ☐ No**

22. **What additional care will your client need and how will that be arranged? Who will provide needed care coordination?** 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?	
☐	☐	**23.** Risks and benefits of surgery and alternatives to surgery.
☐	☐	**24.** Potential alterations in sexual functioning.
☐	☐	**25.** Sterilization and reproductive choices.
☐	☐	**26.** Impacts of smoking, drugs, and alcohol on surgery and surgical outcomes.
☐	☐	**27.** Importance of aftercare related to post-operative complications and aesthetic outcomes.

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☐	☐	**28.** Realistic expectations about what surgery can and cannot do physically, emotionally, and spiritually.
☐	☐	**29.** Realistic expectations about recovery and post-operative care.
☐	☐	**30.** Mandatory GHSF Education, Preparation and Planning (EPP) program for genital surgery.

31. 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.

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