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The San Francisco Department of Public Health (SFDPH) established Gender Health SF to provide access, education and preparation to gender-related procedures for adult transgender San Francisco residents. The Gender Pre-Surgical Assessment Form is a working collaboration between Gender Health SF, insurance, collaborating clinics, and patients. It is designed to:

1. Structure a comprehensive assessment that will inform how to most effectively educate, prepare and coordinate patients seeking gender-related procedures,
2. Encourage providers to obtain informed consent for surgical intervention, and
3. Assist providers in assessing if surgical intervention to treat Gender Dysphoria is the most effective and appropriate treatment.

**How to complete this form:**

Gender Pre-Surgical Assessments are required to be completed or authorized by a licensed mental health provider. If you are unlicensed, a licensed mental health professional needs to authorize your assessment by meeting with the patient at least once, reviewing and signing the assessment.

For clients seeking gender procedures that have higher complication risks and/or will result in complete sterilization, such as Vaginoplasty, Hysterectomy or Phalloplasty, assessments by two separate licensed mental health providers are required. For all other gender procedures, such as Facial Feminization Surgery, assessment by one licensed mental health provider will suffice.

Due to the wide array of gender procedures available and uniqueness of every patient’s needs, not all questions are applicable. Please note “Not applicable” when appropriate.

**Frequently Asked Questions:**

1. Why is hormone replacement therapy treatment history (Question 3) relevant?

In accordance with WPATH Standards of Care and in order for the GHSF and insurance to authorize certain gender procedures, hormone replacement therapy must be ruled out as an effective medical treatment of Gender Dysphoria. For example, some individuals find that 1 year on hormone replacement therapy develops enough breast tissue growth that surgical intervention is not needed.

1. What does “informed consent” (Question 5) mean?

Informed consent in practice is a provider offering the potential risks, benefits, and alternatives to a proposed treatment to a client. Informed consent is shaped by a client’s capacity to understand and integrate this information to make informed decisions.

1. I am completing an assessment only for Facial Hair Reduction. Do I need to complete an entire Pre-Surgical Assessment?

No. Please answer Questions #1 - #10.

1. What is medical necessity and how is medical necessity determined?

All procedures, services and items covered by insurance must be deemed reasonable and necessary for the treatment of a diagnosis and/or injury. Gender Health SF collaborates with insurance and references WPATH Standards of Care to determine if the treatment requested (gender procedure) is the most reasonable and necessary treatment to treat the patient’s diagnosis (Gender Dysphoria). If your assessment does not meet medical necessity by insurance standards, Gender Health SF will contact you to revise your assessment.

1. Where can I learn more about gender care and assessments?

Gender Health SF offers Gender Pre-Surgical Assessment trainings, as well as surgery-specific provider trainings. Please contact GHSF to be added to our provider mailing list.

Also, every 2nd Tuesday of the month at South Van Ness Adult Behavioral Health Services, 755 South Van Ness, San Francisco, CA, is a Gender Case Consultation group, open to all SFDPH employees and SFDPH-contract employees. If you fit neither criteria and are interested in joining, please contact GHSF.

**Important information:**

To promote best possible outcomes and encourage remaining in care, assessments are reviewed not only to authorize surgery consultation, but surgery date. Assessments expire after 1 year. Your assessment may authorize consultation but expire before surgery date due to wait list status. If this is the case, you may be contacted to update your original Assessment.

Additionally, surgery authorization denials and surgery date cancellations often cause significant distress for clients. If you have additional questions, Gender Health SF offers clinical consultation to support providers in completing effective assessments.

**\*\*\*\*\*\*\*\*\*\*\*\*\* PLEASE KEEP INSTRUCTIONS (PAGES 1-2) FOR YOUR RECORDS \*\*\*\*\*\*\*\*\*\*\*\*\***

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\* PLEASE FAX ONLY THE ASSESSMENT FORM BELOW \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**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**. 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?**

Facial hair reduction (electrolysis/laser)

Feminizing Mammoplasty (breast augmentation)

Facial Feminization Surgery

Orchiectomy

Vulvoplasty/Labiaplasty

Vaginoplasty

Subcutaneous mastectomy with male chest reconstruction (“chest surgery”)

Hysterectomy/Oophorectomy

Metoidioplasty

Phalloplasty

A procedure not listed here. Please describe: 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. **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**

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.

**Surgery Preparation and Aftercare**

1. **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.
2. **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.

1. **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**

1. **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.

1. **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**

1. **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.
2. **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.
3. **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.
4. **Describe your client's support system and relationships. Who will help with recovery?** Click here to enter text.
5. **Describe stressors that may interfere with your client’s recovery, such as impending homelessness or living with unsupportive roommates.** Click here to enter text.
6. **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**
7. **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.***

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| Reviewed | GHSF F/U? |  |
|  |  | 1. Risks and benefits of surgery and alternatives to surgery. |
|  |  | 1. Potential alterations in sexual functioning. |
|  |  | 1. Sterilization and reproductive choices. |
|  |  | 1. Impacts of smoking, drugs, and alcohol on surgery and surgical outcomes. |
|  |  | 1. Importance of aftercare related to post-operative complications and aesthetic outcomes. |
|  |  | 1. Realistic expectations about what surgery can and cannot do physically, emotionally, and spiritually. |
|  |  | 1. Realistic expectations about recovery and post-operative care. |
|  |  | 1. Mandatory GHSF Education, Preparation and Planning (EPP) program for genital surgery. |

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

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 PCP so the PCP can review and submit a complete referral to Gender Health SF.**

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