Client's preferred name and legal name:       DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician name:       Office location or clinic:

Please describe your experience completing gender related care and assessments.

Dates that you evaluated this client for appropriateness and readiness of surgical treatment for gender dysphoria.

Does this client have the capacity to give informed consent? If no, please explain.

Please give a brief description of this client, and their history of gender dysphoria and their attempts to address their dysphoria.

How will genital surgery improve the person's functioning? How will it make their life better? Please use the patient's words.

Has the client lived full time in their gender? Yes  No  If not please explain.

Please list **all** DSM diagnoses:

What is your assessment of the client's functioning? What is your assessment of their capacity to satisfactorily complete ADLs and IDLs? (Activities of Daily Living and Instrumental Activities of Daily Living.)

Does this client have a mental health issue that surgery, anesthesia, or the stress of recovery could cause them to decompensate?       Please indicate how this will be addressed, if present.

Please list any concerns you have with the patient’s ability to comply with medical directives. (e.g. comprehension, reading ability, developmental disorders, mental/physical health considerations)

Please list all medications or supplements for psychiatric care, emotional problems and sleep.

(This may include medical marijuana.)

Who prescribes these medications?

Please list any concerns you have with the patient's ability to comply with medical directives:

List the results of the CAGE or other substance abuse screening for the client.

Please describe all current and past substance use including nicotine and caffeine.

List any concerns the client reports over their drug or alcohol use or their sobriety and their plan to address any substance use.

Please describe client's housing situation:

Please describe the client's plan for after care: (How will they support self, get to follow up appointments, have food)

How realistic is the client's plan for aftercare in your opinion?

What additional care will your client need and how will that be arranged?

The length of time your client has taken hormones and their response to hormones.

Your rationale for the referral for surgery:

Please indicate that you discussed these issues to your client's satisfaction:

Sterilization and reproductive choices.

Potential alterations in sexual functioning.

Risks and benefits, alternatives to surgery.

The impact of drugs or alcohol on surgery and outcomes.

The mandatory education/preparation program.

The importance of aftercare related to post-operative complications and aesthetic outcomes.

Is the client's gender identity stable and consolidated? Yes  No

Did you speak with previous mental health providers? Yes  No

Do you believe this client has realistic expectations about what the procedure can and can not do? Yes  No

Do you believe the client is capable of carrying out their aftercare plan? Yes  No

Do you believe this client can provide for their own self-care following surgery? (dilation 3x per day, hygiene issues, monitoring for infection, getting adequate nutrition, etc.) Yes  No

Do you believe that this client is likely to benefit from surgical intervention? Yes  No

Please print out this form and sign it. Fax it to: 415-755-7407

Your name, title and license

Your signature:

Date:

Phone number for follow up: