Transgender Sex Reassignment Surgery Services
Medical Evaluation Form

Instructions: Please mark either “yes” or “no” for every item. All items must be completed.

Yes No
☐ ☐ This patient has gender dysphoria

Hormone Therapy History
(Mark only one “yes”; the other three should be “no”)

Yes No
☐ ☐ This patient has taken 12 continuous months of hormone therapy as appropriate to the patient’s gender goals
☐ ☐ Hormone therapy is not appropriate for this patient’s gender goals
☐ ☐ This patient has medical contraindications to hormone therapy
☐ ☐ This patient is unable or unwilling to take hormone therapy

Medical conditions that could interfere with expected outcomes of proposed surgery

Yes No
☐ ☐ Uncontrolled diabetes
☐ ☐ Active infection
☐ ☐ Severe immunosuppression
☐ ☐ Un stable cardiovascular disease
☐ ☐ History of venous thromboembolism
☐ ☐ History of poor wound healing
☐ ☐ Obesity BMI: ________
☐ ☐ Other unstable medical conditions: _________________________
☐ ☐ None

Other Conditions

Yes No
☐ ☐ Cigarette or Cannabis smoker
☐ ☐ Other significant substance use

If conditions present document plans to stabilize:

☐ ☐ Medical conditions are well controlled
☐ ☐ This patient has been engaged in medical care within DPH affiliated clinics for >1 year and attends medical visits regularly
☐ ☐ It is my opinion that the proposed surgery will benefit this patient’s health

Medical Provider Name Signature Date

_________________________ ___________________________ __________