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| transgender health services Black logo FINAL | **San Francisco Department of Public Health**  **Gender Health SF**  955 Potrero Avenue  Building 80, 8000N  San Francisco, CA 94602  Telephone: (415) 206-7979  Fax: (415) 206-7999  [transgenderhealthservices@sfdph.org](http://www.sfdph.org/dph/comupg/oprograms/THS/transgenderhealthservices@sfdph.org)  [www.sfdph.org/transgenderhealthservices](http://www.sfdph.org/transgenderhealthservices) |

**Presurgical assessment documentation Form for Gender Confirmation Surgery**

Client's name: Click grey box to enter text.

Legal name if different:

DOB:

Clinician Name:

Office location or clinic:

Are you licensed?  Yes  No (Assessments must be completed by licensed providers.)

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 evaluated this client for readiness and appropriateness for surgical intervention? (If two people are signing the same letter, please list the dates you each evaluated the client or use 2 separate forms.)       Click here to enter text.

Is this a:

Single assessment or first assessment (Breast or chest surgery or facial feminization or facial hair reduction require one assessment )

Second assessment? (Genital or sterilization surgeries require 2 assessments)

For which surgeries are you referring your client?

Orchiectomy

Penectomy

Vaginoplasty

Vulvoplasty/Labiaplasty

Feminizing mammoplasty (breast augmentation)

Facial hair reduction (electrolysis/laser)

Facial Feminization Surgery

Subcutaneous mastectomy with male chest reconstruction

Hysterectomy/Oophorectomy

Phalloplasty

Metoidioplasty

A surgery not listed here. Please describe:

1. Please give a description of 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. 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.
4. 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.
5. For clients considering vaginoplasty, orchiectomy, metoidioplasty, and phalloplasty: The 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.
6. Please describe your rationale for the referral for surgery at this time.       Click here to enter text.
7. Describe the client’s capacity to give informed consent for surgery? If they lack capacity, please explain.       Click here to enter text.
8. Are there issues the surgeons need to know about regarding communication? These could include English fluency, hearing impairments, autism spectrum, literacy level, learning differences, etc.       Click here to enter text.
9. 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, improve their health, or decrease symptoms? Please include the client's words.       Click here to enter text.
10. Please give a brief description of your client's behavioral health history, including suicidality, homicidality, a history of violence towards healthcare workers, any psychiatric hospitalizations, and residential treatment for mental health or substance use.       Click here to enter text.
11. Please list all current and past behavioral health diagnoses.       Click here to enter text.
12. Please list all medications that the client is currently taking related to psychological concerns, sleep, or emotional problems (include supplements, like St. John's Wort and medical marijuana). These can affect anesthesia, bleeding and pain control. *Please list the prescriber’s name next to the medication.*       Click here to enter text.
13. How will your client’s mental health concerns be effected by the stress of surgery, anesthesia, or recovery? For instance: trauma, anxiety disorders, depression, bipolar disorder, schizophrenia, substance abuse. (Surgery can precipitate a relapse or decompensation.)       Click here to enter text.
14. Please describe how you have prepared your client for this possibility and your prevention and intervention plan.       Click here to enter text.
15. Please screen for substance use and list the result of the AUDIT or AUDIT-C. (You can find this on our website or on instruction page.)       Click here to enter text.
16. Please describe current and past substance use, including nicotine. Please list any concerns the client has regarding their substance use or their sobriety and pain medication.       Click here to enter text.
17. Smoking cigarettes or marijuana and use of nicotine in any form can cause surgery to be cancelled. What was the date of their last use of nicotine? What is your client’s plan to stop nicotine use prior to surgery? Do you believe the plan is realistic? What services were they offered to assist them? Who is assisting them to ensure they stop? (They can be referred the smoking cessation program at GHSF, CLASH, or through their PCP.)       Click here to enter text.
18. Substance use can cause problems related to anesthesia, bleeding and pain control. If the client uses substances, including alcohol, what is the plan to reduce or stop substance use before surgery? Do you believe the plan is realistic? What services were they offered to assist them?       Click here to enter text.
19. Please describe any medical problems your client may have that may interfere with surgery. What is your client’s plan to manage these problems? (Obesity, uncontrolled diabetes, sleep apnea, etc.)       Click here to enter text. Have you consulted with their PCP? Yes No
20. What is your assessment of your client's functioning, including their ability to satisfactorily complete ADL's and IDL's? (Activities of Daily Living and Instrumental Activities of Daily Living.)       Click here to enter text.
21. What type of work do they do? How does your client support themselves financially?       Click here to enter text.
22. Please describe your client’s housing situation. Is your client homeless or living in a shelter? If they are having genital surgery do they have a safe private bathroom?       Click here to enter text.
23. Describe your client's support system, relationships, and family support. Who will help as the client recovers?       Click here to enter text.
24. Describe stressors that may interfere with your client’s recovery (impending homelessness, abusive partner, lives with unsupportive parents, etc.)       Click here to enter text.
25. 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, hygiene issues, monitoring for infection, getting adequate nutrition, staying housed, paying bills, etc.) Yes No
26. What additional care will your client need and how will that be arranged? Who will provide needed care coordination?       Click here to enter text.
27. If the client wants genital or facial surgery, which surgeon is the client requesting?       Click here to enter text.

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

1. Potential alterations in sexual functioning. (All clients-see instructions)
2. Risks and benefits of surgery and alternatives to surgery.
3. The impact of smoking, drugs, and alcohol on surgery and surgical outcomes.
4. The importance of aftercare related to post-operative complications and aesthetic outcomes.
5. The mandatory education/preparation program for genital surgery.
6. Sterilization and reproductive choices. ( Genital surgeries and chest feeding)
7. Do you believe your client has realistic expectations about what each surgery requested can and cannot do physically and psychologically?Yes No
8. Do you have any hesitation or concern that the client may regret or not benefit from a surgical intervention at this time?
9. Do you believe your client has realistic expectations about their recovery and post-operative care? Yes No
10. Is there anything you would like to add?      Click here to enter text.

Your name, title and license:       Click here to enter text.

Your signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: Click here to enter text.

Your phone number for follow up: Click here to enter text.

The SFHP requests that you are available for consultation and for care coordination.

Please print out this form and sign it.

Fax it to: Gender Health SF at 415-206-7999