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| transgender health services Black logo FINAL | **San Francisco Department of Public Health****Transgender Health Services**50 Lech Walesa StreetSan Francisco, CA 94102Telephone: (415) 355-7513Fax: (415) 355-7407[transgenderhealthservices@sfdph.org](http://www.sfdph.org/dph/comupg/oprograms/THS/transgenderhealthservices%40sfdph.org) [www.sfdph.org/transgenderhealthservices](http://www.sfdph.org/transgenderhealthservices) |

**Therapist Documentation Form for Evaluation for Transgender Surgery 7/2016**

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.

It this a:

[ ]  Single assessment or first assessment (Breast or chest surgery or facial feminization or facial hair reduction require one assessment; genital surgery or sterilization requires two )

[ ]  Second assessment? (necessary for genital or sterilization surgeries)

For which surgery (or 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:

Please list the dates that you evaluated this client for readiness and appropriateness for surgical intervention?

Which current or previous medical and/or mental health providers did you speak with in your evaluation? What were their thoughts?

Please give a description of this client, identifying characteristics, age, ethnicity, language, gender identity, etc. and their history of gender dysphoria and emphasize their attempts to address their gender dysphoria.

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.)

For patients 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.

Please describe your rationale for the referral for surgery at this time.

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

If the patient wants genital surgery, which surgeon is the patient requesting?

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.

For *each* surgery your client is requesting, please describe how each surgery will improve your client's functioning? How will it make their life better? Please use the client's words.

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.

Please list all current and past DSM Diagnoses.

Please list all medications that the client is currently taking related to psychological concerns, sleep, or emotional problems (this should include supplements, like St. John's Wort and medical marijuana). *Please list the prescriber’s name next to the medication.*

Does your client have a mental health problem that the stress of surgery, anesthesia, or recovery may cause your client to decompensate? For instance: PTSD, anxiety disorders, depression, bipolar disorder, schizophrenia, substance abuse, etc.

Please describe how you have prepared your client for this possibility and how this will be addressed.

Please screen for substance use and list the result of the CAGE, DAST or other substance abuse screening tool.

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.

Nicotine or can cause surgery to be cancelled. 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?

Substance use can cause problems related to anesthesia and pain control. If the patient 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?

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.)

Please describe your client’s housing situation and any concerns regarding their recovery. Is your client homeless or living in a shelter? If they are having genital surgery do they have a safe private bathroom?

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.)

Describe your client's support system, relationships, family support, and work. Who will help when the patient recovers?

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

What additional care will your client need and how will that be arranged? Who will provide needed case management?

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

 [ ]  Potential alterations in sexual functioning.

 [ ]  Risks and benefits of surgery and alternatives to surgery.

 [ ]  The impact of smoking, drugs, and alcohol on surgery and surgical outcomes.

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

 [ ]  The mandatory education/preparation program for genital surgery.

 [ ]  Sterilization and reproductive choices. (Genital surgeries only)

Is your client's gender identity stable? [ ] Yes [ ] No

Do you believe your client has realistic expectations about what each surgery requested can and cannot do physically and psychologically?

[ ] Yes [ ] No

Do you have any hesitation or concern that the client may regret or not benefit from a surgical intervention at this time?

Do you believe your client has realistic expectations about recovery and post-operative care ?

[ ] Yes [ ] No

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.

Please print out this form and sign it.

Fax it to: 415-355-7407