COMMUNITY HEALTH
CENTER NETWORK

Therapist Documentation Form for Evaluation of Transgender Surgery

Client's name:
Legal name:
Date of Birth:

Clinician's name:
Clinician's title and license:

Please describe your experience completing assessments for gender related surgeries:

For which surgery or surgeries are you referring your client? (Please select all that apply)

- ☐ Orchiectomy
- ☐ Penectomy
- ☐ Vaginoplasty
- ☐ Hysterectomy/Oophorectomy
- ☐ Phalloplasty
- ☐ Metoidioplasty
- ☐ Feminizing mammoplasty (breast augmentation)
- ☐ Subcutaneous mastectomy
- ☐ A surgery not listed here. Please describe:

Please list the dates 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?

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

Please indicate the length of time your client has taken hormones and their response to hormones.

For patients considering gender conforming surgery, the standards of care state that the patient must have at least 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.

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

Are there any issues the surgeons need to know about regarding communication? These could include English fluency, hearing impairments, an autism spectrum disorder, literacy level, learning differences, etc.

Please document the specific impairment that will be addressed by the proposed procedure. How will this particular surgery improve your client's functioning? How will it make their life better? Please include the client's words if applicable.

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

Please give a brief description of your client's mental health history, including suicidality, homicidality, a history of violence towards healthcare workers, any psychiatric hospitalizations, and residential treatment for mental health or substance abuse.

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, such as 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, schizophrenia, substance abuse, etc.

☐ Yes ☐ No

Comments:

LŦ I·yãøŜℕ ú2 LJℕŜØℳ2ďžă IjďzŜăúℳ2y˙ℳă ěŜăΣ LJlease describe how you have prepared your client for this possibility and how this will be I·ŘŘℕŜăăŜŘφ

Please list the result of the CAGE or other substance abuse screening tool.

Please describe current and past substance use, including nicotine. Please list any concerns you have or that your client has regarding their substance use or their sobriety and pain medication.

Please describe medical problems your client may have.

What is your client's function, including their ability to satisfactorily complete ADLs and IDLs?

Describe your client support system, relationships, family support, and work.

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, etc.) ☐ Yes ☐ No

Comments:

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

Please explain your rationale for the referral for this surgery.

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

- ☐ Potential alterations in sexual functioning
- ☐ Risks and benefits, alternatives to surgery
- ☐ The impact of drugs and/or alcohol on surgery and outcomes
- ☐ The importance of aftercare related to post-operative complications and aesthetic outcomes
- ☐ The mandatory education/preparation program (Vaginoplasty, metoidioplasty, and phalloplasty only)
- ☐ Sterilization and reproductive choices (Genital surgeries only)

Is your client's gender identity stable and consolidated?

☐ Yes ☐ No

Do you believe your client has realistic expectations about what the surgery can and cannot do?

☐ Yes ☐ No

Is there anything you would like to add?

Signature: _____ Date: _____

Please fax completed form to 510-297-0222

For questions, please contact CHCN Utilization Management department at 510-297-0481 or umcod@chcnetwork.org.