Medical & Behavioral Health Assessment Letter

Dear Dr. Chandler, _____
(today's date)

This letter is to inform you that _____DOB_____
(Patient's name)

has been an established patient at _____,since_____.
(Name of Facility)

This patient identifies as ☐Female ☐Male ☐Non-Binary/They; and has been living in this role for

_____.
(Dates and Length of Time)

I am a licensed professional _____, who has regularly seen the
(MD, PhD, APRN, LCSW, Other)

patient for _____.
(ICD-10 Diagnosis)

The patient has already undergone (mark the following):

☐Continuous Psychotherapy (dates & length of time) _____

☐Continuous Hormone Therapy (dates & length of time) _____

☐Surgeries/Date (Breast Augmentation, Facial Feminization, Orchiectomy, Other)

_____

History of Mental Illness/Substance Use: ☐Yes ☐No (Please explain below)

_____

_____

Are there any other current psychological conditions: ☐Yes ☐No

If so, are they reasonably well controlled: ☐Yes ☐No

If significant medical or mental health conditions are present, please confirm that they do NOT interfere with self-identification and do NOT put the patient at unreasonable risk:

☐Yes, I confirm the above statement ☐No, explain:

_____

_____

Is this patient diagnosed with gender dysphoria (F64.0)? ☐Yes ☐No

Does the gender identity disorder/gender dysphoria cause clinically significant distress or impairment in social, occupational, or other important areas of functioning? ☐Yes ☐No

Psychosocial Stability: Housing, support (i.e. family, friends, coworkers), postoperative care plan (please explain below):

_____

_____

Adequate for postop care? ☐Yes ☐No

Does the patient understand the risks and benefits of Gender Affirming Surgery, and that this surgery is irreversible? ☐Yes ☐No

Does the patient have the capacity to consent for themselves? ☐Yes ☐No

In your opinion, does the patient meet the Mental Health Criteria for Gender Affirming Surgery, in which the patient is psychologically stable for surgery and the recovery period? ☐Yes ☐No

Signature: _____ Date: _____

Print Name Here: _____

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PLEASE FAX TO 203-423-0124 WHEN AVAILABLE***