Dr [Doctor Name]
[Qualifications]
[Type of physician]
Medicare Provider:

[DATE]

**Re: Gender affirming hormones for [Patient Name]**

You can find and replace the following terms: [Patient Name] [Patient First Name] [Doctor Name] & [Type of physician].

You can also replace the pronouns in this letter by replacing [Pronoun 1] with the singular subject pronoun (e.g. he, she, they) and [Pronoun 2] with the singular possessive pronoun (e.g. his, her, their)

Thank you for attending [Patient Name], who is ready for gender affirming hormones as part of their gender affirmation.

[Patient First Name] is [patient’s identity, e.g. a trans woman / a non-binary person]. [Pronoun 2]’s pronouns are [Pronoun 1]/[Pronoun 2].

[Patient First Name] was assessed on [DATE].

[Describe original assessment, and the results of their psychosocial assessment of you, including any diagnoses.]

[Describe how long you’ve been seeing each other, including the type of evaluation and therapy or counselling provided.]

[Specifics re medical and mental health concerns and their control]

[Patient First Name] has a strong understanding of the nature, purpose and outcomes of gender affirming hormones.

[Any additional insights]

[Patient First Name]’s capacity to consent to this procedure was specifically assessed.

• Prepared to make decision

• Has a solid plan for gender affirmation

• Understands alternatives

• Retains information – and recalls the advantages and disadvantages

• Can balance those factors to arrive at a decision

• Understands nature and purpose of gender affirming hormones

• Understands concepts of permanence and irreversibility

• Freedom from pressure, including pain, to make this decision

• Treatment is in their best interest

• Sufficient intellect and maturity to make the decision

• Meets all criteria outlined in WPATH Standards of Care version 7

[Patient First Name] has demonstrated capacity to make an informed decision regarding starting gender affirming hormones. [Pronoun] fulfils the World Health Organization International Classification of Diseases (ICD-11) criteria for *Gender Incongruence in Adults and Adolescents*, in that:

1. [Pronoun 1] has a persistent incongruence between [Pronoun 2] experienced gender and [Pronoun 2] assigned sex at birth
2. [Pronoun 1] has capacity to make informed decisions as described above
3. [Pronoun 1] is [age] years of age, and is thus legally emancipated to make informed medical decisions
4. [Pronoun 1] medical and mental health concerns are reasonably controlled

I support [Patient Name]’s decision to start gender affirming hormones and believe that it is in [Pronoun 2] best interest. This procedure is a medical necessity.

Please do not hesitate to contact me if you have any questions or concerns.

[Signature]

Yours sincerely

Dr [Doctor Name]
[Type of physician]