Surgical Endorsement Letter Requirements

- ❑ Date patient began HRT or why patient is unable or does not desire to be on hormones (i.e., medically not appropriate or not aligned with gender identity, such as gender non-binary)
- ❑ Patient's Adherence to HRT (if applicable)
- ❑ Outcome to patient's current HRT (if applicable)
- ❑ Any comorbidities patient may have that will interfere with surgery
- ❑ Statement that patient is a good surgical candidate
- ❑ Statement that surgery is next reasonable step in patient's care
- ❑ Statement that surgery is medically necessary
- ❑ **Must be signed and dated within 18 months of consult date**

Additional needs:

- ❑ Your clinical license or credential information
- ❑ Statement confirming the diagnosis gender dysphoria (DSM 5)
- ❑ Letters must be **hand written (**or printed out **and signed in ink)** and **scanned** into Epic's media tab for easy retrieval

Sample PCP surgical endorsement letter

[on letterhead]
[date]

Re: [patient name on insurance card], [patient's chosen name], [patient DOB]

Dear Doctor,

[Patient name] is a patient in my care at [your practice name]. They have been a patient here since [date]. They identify as [gender identity] and go by [pronouns]. They note that they first knew their gender identity differed from their assigned sex at age [age]. They have socially transitioned by [list how - change name, pronoun, dress, make-up, hair, tuck, pack, binding, coming out etc). They have been successfully and consistently living in a gender role congruent with their affirmed gender since [date]. They have been consistently on hormone therapy since [date] (If contraindicated or chosen not to take hormones, state that here). Despite, these interventions, they report significant anxiety, depression, and distress due to their experience of dysphoria. By my independent evaluation of [patient name], I diagnosed them with Gender Dysphoria (ICD-10 F64.1). They have expressed a persistent desire for [surgery]. Their goals of surgery are [goals]. Surgery will address their gender dysphoria in these ways: [explain].

[Patient name] is physically healthy to undergo this surgery. [list any medical and mental health diagnoses that may be relevant to having surgery]. Their current medications include [medications]. Their surgical history includes [surgical history]. They are stably housed and have prepared for their post-op recovery (if this is true, if not, state plan for post-op recovery). They have no issues with illicit drug use or abuse (if this is true, if not, explain plan of care for stabilization).

[Patient name] has more than met the WPATH criteria for [surgery]. I have explained the risks, benefits, and alternatives of this surgery and believe they have an excellent understanding of them. They are capable of making an informed decision about undertaking surgery. I believe that the next appropriate step for them is to undergo [surgery], and I believe this will help them make significant progress in further treating their gender dysphoria. Therefore, I hereby recommend and refer [patient name] to have this surgery.

If you have any questions or concerns please do not hesitate to contact myself or my office.

Sincerely,