Mental Health Assessment Letter Requirements

- ❑ Statement confirming the **diagnosis** gender dysphoria (DSM 5)
- ❑ Your clinical **license** or credential information
- ❑ Assure the client/patient is a **good candidate for surgery** (consult surgery endorsement letter if needed or possible).
- ❑ Assure the surgery is the **next reasonable step** to treat patient's gender dysphoria
- ❑ Assure any mental health or co-existing behavioral issues present are **reasonably well controlled** and managed
- ❑ A statement indicating the client/patient exhibits a strong **persistent gender identification** outside of their assigned gender at birth.
- ❑ A statement indicating the client/patient exhibits **persistent discomfort** with their assigned sex and gender role of that sex.
- ❑ A statement indicating that the client/patient's gender dysphoria **causes clinically significant distress** or impairment in important areas of functioning (social, occupational, interpersonal, etc.,)
- ❑ **The date** the client/patient started their social transition or began living as their stated gender identity, or any medical or other barriers that may be preventing this

WA HCA

Sample Mental Health Provider Letter

[Letterhead]
[Date]

Patient Name: [Name of Patient]
[Legal name if different]
Pronouns: [Patient's Pronouns]
Patient DOB: [DOB]

Dear Dr. [Surgeons Name],

I am writing this letter of support on behalf of my client [Name of Patient] who has been seeing me for therapy since [Date of first Visit] and/or was evaluated by me on [Assessment Date] for gender affirming surgery [Name of the Surgery or Procedure – metoidioplasty/vaginoplasty/phalloplasty/hysterectomy/oophorectomy/orchiectomy/bilateral reduction mammoplasty with chest reconstruction/ breast augmentation].

[Name of Patient] identifies as [gender identity] and was assessed for and diagnosed with Gender Dysphoria (F46.1) by [diagnosis provider, and date if possible]. As part of their ongoing medical care for Gender Dysphoria as documented by [Name of Primary Care, mental health, or surgical provider], [Name of Patient] is receiving/has received [list gender affirming care - mental health support/ Hormone Therapy Replacement (HRT)/ previous surgical care]. [Name of Patient] endorses significant distress over incongruence between [pronoun] sex assigned at birth and gender identify/anatomy/etc. A complete psychosocial evaluation was performed and [patient name] is found to have no coexisting behavioral health diagnoses.

*OR the patient is found to have coexisting behavioral health diagnoses [Dx list] which are adequately managed by [___] and not a barrier to surgical candidacy. *(i.e. "The patient meets criteria for diagnoses of anxiety and depression which are adequately managed by therapy and antidepressants.")*

**For patients that are not medically safe to receive HRT or do not desire HRT, this must be indicated as well. For example, "As part of their ongoing medical care for Gender Dysphoria [Name of Patient} receives gender affirming mental health support, or gender affirming medical guidance from their medical provider, but does not desire HRT at this time as it does not affirm their non-binary gender identity at this time."*

[Name of Patient] has identified and presented as [gender identity] for [time frame]. At this time [patient name] desires to pursue [gender affirming surgery], in order to relieve [pronoun] Gender Dysphoria. We have discussed the variety of ways that [Patient name] has changed [pronoun] gender presentation over time, and how these changes have relieved [pronoun] dysphoria. I see no present or uncontrolled psychiatric conditions that would contradict surgical readiness and would support [patient's] care team recommendations for surgery as the next reasonable step to treat [patient's] gender dysphoria.

[Patient name] has demonstrated an understanding of the permanence, costs, recovery time, and possible complications of [gender affirming surgery] and is fully capable of making an informed decision about surgery. [Patient name] is reasonably expected to follow pre and post-surgical treatment recommendations responsibility. *(i.e. The patient's description of the above match what the surgeon, primary care, and/or master's level mental health provider letter state in terms of prep prior to surgery and needs post-operatively).*

It is my opinion that [Name of patient] is mentally, emotionally, and practically ready for [surgery]. If you would like to discuss this in more detail, please call me.

Thanks,

Provider Name, MSW, LICSW
Your clinical license or credential information
Provider Location
Provider Phone Number

CONFIDENTIAL – DO NOT DISTRIBUTE