Mental Health Provider Letters

Letter requirements

- A statement confirming the **diagnosis** of gender dysphoria
- Your clinical **license** or credential information
- A statement indicating **your experience** in providing gender affirming care
- Assure the client/patient is a **good candidate for surgery**
- Assure the surgery is the **next reasonable step** to treat the client/patient's gender dysphoria
- Assure any mental health or co-existing behavioral health issues 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 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
- The letter is **signed by hand** (i.e. "wet signature") – Digital signatures are rejected by insurance

Sample Letter

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

To Whom It May Concern:

I am writing this letter of support on behalf of my client, [Patient Name], who has been seeing me for therapy since [Date of First Visit] and/or was evaluated by me on [Assessment Date] for gender affirming [Name of Surgery, e.g. breast augmentation, hysterectomy, mastectomy, metoidioplasty/phalloplasty, orchiectomy, vulvovaginoplasty, etc.]. I am experienced in providing gender affirming care to transgender and gender diverse patients. [You can state how long you have been providing gender affirming care.]

[Patient Name] identifies as [Gender Identity] and was assessed for and diagnosed with Gender Dysphoria (F64.1), documented by [Name of Provider]. [Patient Name] is receiving/has received [List gender affirming care, e.g. mental health support, Hormone Therapy Replacement (HRT), previous surgery, etc.]. However, [Patient Name] still endorses significant distress over incongruence between [Pronoun] sex assigned at birth and gender identity.

*A complete psychosocial evaluation was performed, and [Patient Name] is found to have no coexisting behavioral health diagnoses. ***OR** [Patient Name] is found to have coexisting behavioral health diagnoses [List] which are adequately managed by [Management methods]. These are not a barrier to surgical candidacy.

**For patients who do not receive HRT, state that here. *(i.e. "As part of ongoing care for Gender Dysphoria, [Patient Name] receives gender affirming mental health support and medical care but does not desire HRT at this time as it does not affirm their nonbinary gender identity at this time.")*

[Patient Name] has identified and presented as [Affirmed Gender] for [Time Frame]. [Patient Name] desires to pursue [Name of Surgery] to relieve gender dysphoria. We have discussed the variety of ways that [Patient Name] has changed gender presentation over time, and how these changes have relieved dysphoria. I see no present or uncontrolled psychiatric conditions that would contradict surgical readiness and support [Patient Name]'s care team recommendations for surgery as the next reasonable step to treat [Pronoun] gender dysphoria.

[Patient Name] has demonstrated an understanding of the permanence, costs, recovery time, and possible complications of [Name of 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 responsibly.

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

Sincerely,

[Handwritten Signature]

Provider Name, MSW, LICSW [Cosigner required if associate]
Your clinical license or credential information
Provider Location
Provider Phone Number