

## INFORMED CONSENT FOR ESTROGEN THERAPY

### For Male to Female Transition Fenway Community Health – Transgender Health Program

This form refers to the use of estrogen by persons who wish to become more feminized as part of a gender transitioning process.

Your initials of the various statements on this form to indicate that the risks as well as the changes which may occur as a result of the use of estrogen have been explained and that you understand them. If you have any questions or concerns about this information, you are encouraged to take the time you need to ask for clarification, read, research, talk with staff and think about the potential effects of this treatment before signing.

*IF YOU DO NOT UNDERSTAND THIS INFORMATION STOP AND ASK FOR CLARIFICATION*

Please initial each section below to indicate that you understand and agree with the statements.

\_\_\_\_\_ 1. I have been informed that the feminizing effects of estrogen can take several months to become noticeable and several years to be complete. Some of these changes will be permanent including:

- Breast development. Breast development may take years to reach full size. There are natural variations in the size of breasts, and one person's breast development will not correlate with that of another person's. If estrogen therapy is discontinued, there may be some breast shrinkage, but breast development will not completely disappear.
- Brain structures are affected by testosterone and estrogen. The long term effects of changing the levels of one's hormones through the use of estrogen therapy and testosterone suppressants has not been scientifically studied and are impossible to predict. These effects may be beneficial, damaging, or both.
- Changes in fertility and sperm production (see information below in # 5).

These additional changes will not be permanent if I stop taking estrogen:

- Decreased acne
- Male pattern balding stops or slows (no loss of hair will be reversed once gone)
- Skin may become softer
- Facial and body hair growth may *decrease* (not stop) in thickness or quantity to a greater or lesser extent
- Redistribution of body fat to a more female pattern (i.e., abdominal fat may decrease while fat on the buttocks and thighs may increase)

\_\_\_\_\_ 2. I understand that estrogen may cause or contribute to depression. If I have a history of depression I will discuss this with my provider to explore treatment/therapy options that are available to me.

\_\_\_\_\_ 3. I understand the effects of estrogen will not protect me for sexually transmitted diseases or HIV and that condoms or barrier methods should be used.

\_\_\_\_\_ 4. Due to breast development with estrogen therapy, I understand that I will need to do monthly breast self-examinations, have an annual medical exam, and, once I am 40 or older, I will need to have an annual mammogram.

\_\_\_\_\_ 5. I understand that estrogen therapy will decrease hormones that support the size and function of my testicles, which may then effect overall sexual functioning and fertility. The changes that may occur include:

- a. Up to 40% shrinkage in size of the testicles.
- b. Decrease in testosterone production from the testicles
- c. The amount and quality of erections and ejaculation may decrease or stop entirely.
- d. Sperm will still be present in the testicles, but may stop maturing which may cause infertility.
- e. If estrogen therapy is stopped, the ability to make sperm healthy, mature sperm may or may not ever come back.
- f. Erections may no longer be firm enough for penetrative intercourse.
- g. There may be a decrease or loss of morning and spontaneous erections.

h. Sex drive or libido may decrease.

\_\_\_\_\_ 6. I understand that taking estrogen can significantly increase the risk of blood clots (thrombosis), which can result in:

- a. death
- b. deep vein thrombosis
- c. chronic leg vein problems
- d. pulmonary embolism (blood clot to the lung, which can cause permanent lung damage or death)
- e. cerebral vascular accident (stroke) which may result in permanent brain damage, blindness, paralysis, difficulty talking or death.

\_\_\_\_\_ 7. I understand that ***the risk of blood clots, heart attack, and stroke on estrogen therapy is increased further high if I smoke tobacco***, especially if I am over the age of 35. I have been informed that my medical provider can offer me several options to support and assist me with the process of stopping smoking if so desired or needed.

\_\_\_\_\_ 8. I understand that estrogen can cause increased blood pressure. If I have existing high blood pressure and it is controlled with medication and/or diet and exercise, I understand that I may be able to take estrogen safely with close medical monitoring.

\_\_\_\_\_ 9. I understand that estrogen use may lead to liver inflammation or liver disease. I agree that while I am on estrogen therapy I will be monitored for liver problems before and periodically during therapy. I understand that there is a slight risk of long-term estrogen use causing liver cancer.

\_\_\_\_\_ 10. I understand that estrogen may increase migraine headaches and that this may be a reason for me to choose to stop taking estrogen or may be a reason for estrogen to be discontinued by my provider.

\_\_\_\_\_ 11. I understand that estrogen may cause nausea and vomiting, similar to morning sickness in a pregnant woman. If I experience nausea and vomiting that are severe and/or prolonged, I understand that I will require medical attention and a change or discontinuation of hormone therapy to prevent serious physical damage to myself.

\_\_\_\_\_ 12. I understand that the most dangerous side effects from estrogen therapy occur in connection with smoking cigarettes, being overweight, being over 40 years old, having a history of blood clots, high blood pressure, or prior estrogen dependent cancer. I understand that estrogen therapy may be discontinued or adjusted at any time if concerns or complications arise which are threatening to my continued physical and/or psychological well-being.

\_\_\_\_\_ 13. I understand that estrogen may cause changes in my cholesterol. My HDL (good cholesterol) may go up and my LDL (bad cholesterol) may go down.

\_\_\_\_\_ 14. I understand that estrogen may prevent prostate problems. I have been informed that there is a slight chance that taking estrogen will cause overgrowth of the prostate. Prostate cancer screening is recommended for people 50 years of age and older as well as in younger people if otherwise medically indicated.

\_\_\_\_\_ 15. I agree to tell my medical provider about any non-clinic hormones, dietary supplements, herbs, recreational drugs or medications I might be taking. I also understand that any of the above items may be detrimental to my health and could be interact negatively with estrogen. I have been informed that clinic staff will continue to provide me with medical care, regardless of what information I share with them.

\_\_\_\_\_ 16. I understand that everyone's bodies will respond differently to estrogen and that there is no way to predict what will be my response to hormones. I understand that the correct dosage for me may not be the same as for another person. I understand I must follow *my* prescribed regimen of estrogen treatment to continue to receive hormone therapy at this clinic.

\_\_\_\_\_ 17. I agree to take estrogen and all other transition related medications *as prescribed* and to inform my provider of any problems or dissatisfactions I may have with my treatment. I understand that if I take too much estrogen my body may convert it to testosterone.

\_\_\_\_\_ 18. I will have a complete physical examination annually and lab tests periodically as required to make sure I am not having an adverse reaction to hormone treatment and to continue good health care. I understand that this is required to continue hormone therapy through this health center.

\_\_\_\_\_ 19. I understand that there are medical conditions that could make taking estrogen either dangerous or physically damaging. I agree that if my provider suspects I may have any condition that could be dangerous to me, I will be evaluated for it before the decision to start or continue my hormones is made. I understand that if I do not agree to be evaluated, my prescription for estrogen may be cancelled or refused.

\_\_\_\_\_ 20. I understand that I can choose to stop taking estrogen at any time. I also understand that my provider can discontinue treatment for clinical reasons. I agree to follow a prescribed reduction plan if either of these situations occurs to reduce negative and potentially harmful side effects that may occur if I suddenly stop my hormone therapy.

**All of the above information has been explained to my satisfaction AND (check only one)**

\_\_\_\_\_ I choose to begin Estrogen Therapy. \_\_\_\_\_ I do not wish to begin Estrogen Therapy at this time.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient Name Printed

\_\_\_\_\_  
Date

\_\_\_\_\_  
Medical Provider Signature

\_\_\_\_\_  
Provider Name Printed

\_\_\_\_\_  
Date