

DATE

RE: PATIENT NAME

Name on insurance: NAME ON PATIENT INSURANCE IF DIFFERENT  
DOB

Dear SURGEON NAME,

I am writing on behalf of my client, PATIENT NAME (DOB, NAME ON INSURANCE IF DIFFERENT), whom I would like to refer for SURGERY TYPE. PATIENT NAME has been seeing me for therapy since DATE [OR] was evaluated by me on DATE. PATIENT NAME is being followed in primary care by PCP NAME and has received gender affirming hormone treatment since DATE [IF APPLICABLE].

PATIENT NAME identifies as HOW PATIENT DESCRIBES THEIR GENDER IDENTITY. PATIENT NAME has been living PRONOUN life fully and openly as GENDER IDENTITY for HOWEVER LONG THEY IDENTIFY. PATIENT NAME presents as GENDER IDENTITY in all areas of PRONOUN life. PATIENT NAME has had a positive experience with initial gender affirming hormone treatment [IF APPLICABLE]. However, despite this positive experience, PATIENT NAME, continues to experience significant emotional distress due to PRONOUN body not fully aligning with PRONOUN gender identity. It is in this way, PATIENT NAME meets the criteria for having Gender Dysphoria (ICD 10: F64.1). Having this gender affirming surgery is the next appropriate step to enable PATIENT NAME to continue living as who PRONOUN truly is [OR ARE].

PATIENT NAME has demonstrated understanding of the permanence, costs, recovery time, and possible complications of this surgical gender affirmation procedure. PATIENT NAME is fully capable of making an informed decision about the surgery.

PATIENT NAME is reasonably expected to follow pre and post-surgical treatment recommendations responsibly. PATIENT NAME is emotionally and practically ready for this gender affirmation surgery provided you find PRONOUN medically able. If you would like to discuss PATIENT NAME case in more detail, please call me directly at: (xxx)-xxx-xxxx.

Sincerely,

NAME & CREDENTIALS

ROLE TITLE

PRONOUNS:

EMAIL:

PHONE:

FAX: