FENWAY HEALTH

Youth Gender Affirming Care Behavioral Health Documentation

Dear Parents/Guardians/Family,

The following document is a Youth Gender Affirming Care Behavioral Health Questionnaire to be completed by a qualified Mental Health Provider (MHP). A qualified MHP could be a therapist, social worker, or psychiatrist who is comfortable talking about experiences with gender. If your child already has an MHP that they work with and talk to about their gender, please complete a release of information form so our Behavioral Health Specialist (BHS) can contact them for communication around your child's care. If your child does not have a therapist who they talk to about their gender, our BHS will connect you with our behavioral health team to complete this questionnaire.

Whether your behavioral health care is with your own therapist or with our behavioral health team, the goal of this questionnaire is to learn more about your child's experience with gender and gender dysphoria, their goals for gender affirming care, their skills and strengths, and their family and social support system as it relates to your care.

Please reach out to a member of your care team with any questions or concerns.

Dear Mental Health Provider or Behavioral Health Clinician,

The following document is a Youth Gender Affirming Care Behavioral Health Questionnaire to be completed by a qualified Mental Health Provider (MHP). Per WPATH SOC8, the MHP should have knowledge in gender identity development, gender diversity in children and adolescents, have the ability to assess capacity to assent/consent, and possess general knowledge of gender diversity across the life span. The topics covered in this document relate to the patient's experiences of gender identity and dysphoria, their goals for gender affirming care, and their experiences of puberty, school, social spaces, family, and support systems. This questionnaire also asks for your input on the patient's strengths and potential barriers to care, as well as the benefits and potential concerns for receiving gender affirming care. We also ask if this patient meets the diagnostic criteria for gender incongruence. Per the ICD-11,

> Gender Incongruence of Adolescence and Adulthood is characterised by a marked and persistent incongruence between an individual´s experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual´s body align, as much as desired and to the extent possible, with the experienced gender. The diagnosis cannot be assigned prior the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.

If you have questions about this questionnaire or this patient's care, please do not hesitate to reach out to our Behavioral Health Specialist (BHS) or a member of the care team. We have available resources on conducting assessments for trans and gender diverse clients by request.

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Therapist Information

Name			
Address	city	state	zip
Email			
Telephone		**Fax**	
Best way to contact ☐ Mail ☐ Email ☐ Telephone ☐ Fax			
Best time to contact ☐ Morning ☐ Afternoon ☐ Early Evening ☐ Other (please specify):			
Are you able to complete the attached questionnaire? ☐ Yes ☐ No *If no, please complete this page, and return as described at the end of this document.*			
Do you plan to continue to see this patient at this time? ☐ Yes ☐ No			

Patient Information

Full Name, as listed on insurance or identity documents	
Name Used	**Pronouns**
Date of Birth	**Age**
Gender Identity	**Sex Assigned at Birth**
Length of Treatment	**Frequency of Visits**
Release of Information Signed? ☐ Yes ☐ No *If yes, please attach.*	

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Please complete the below questionnaire. If additional space is needed, you are welcome to attach additional documentation, or respond to these questions in a separate document. If you have any questions, contact information can be found at the end of this questionnaire.

1. **Please describe the patient's experience with gender** (ex: when did they begin to explore their gender, what challenges and supports have they encountered so far).

2. **What are this patient's hopes and expectations for affirming their gender?**

3. **Who actively supports the patient in their gender affirmation?** (ex: specific family members, friends, school, online supports, faith community, community groups, professional helpers, etc.)

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4. **What has this patient's experience of puberty been like?** If they have not started puberty, what is their experience thinking about puberty in the future?

5. **What is this patient's experience of school and other social spaces?**

6. **How would you describe the parent(s)/guardian(s) readiness for the patient to access gender affirming care? Are there particular supports you anticipate parent(s)/guardian(s) or other family members needing or benefiting from?**

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7. **What cultural considerations may be helpful to be aware of when working with this patient, including factors that may be supportive or challenging to their gender affirmation?** (ex: religion, race, culture, and other dimensions of diversity)

8. **What are strengths of this patient that you would like to highlight?**

9. **What are some potential barriers to care?** (ex: lack of parental consent, transportation to appointments, insurance coverage, uncertainty about desired interventions, etc.)

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10. **What coping skills and resources has the patient developed to address potential barriers?**

11. **Please describe the patient's mental health history, including how gender dysphoria may have impacted mental health if applicable** (ex: treatment history, recent changes, coping skills and supports, plans to support safety).

12. **Does the patient meet the criteria for a diagnosis of gender dysphoria?** ☐ Yes ☐ No ☐ Unsure

13. **If applicable, how does the patient manage their experience of gender dysphoria or gender incongruence?**

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14. **Are there things that may impact the patient's experience of or ability to describe their gender identity or gender affirmation goals? If so, please elaborate.** (ex. anxiety, neurodiversity, mistrust of providers, etc.)

15. **What benefits do you believe the patient would experience as a result of pursuing gender affirming medical care?**

16. **What, if any, concerns do you have about this patient pursuing gender affirming medical care?**

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17. **What recommendations, if any, would you like to share for resources and supports as this patient seeks gender affirming medical care?** (ex: ongoing individual therapy, consult for mental health medication, peer support, etc.)

18. **Any other comments?**

Signature ▲ **Date**

Thank you for your time.

If you have any questions, please contact	**At** (Contact option 1)	**Or** (Contact option 2)
Return by		
Use a secure email program to scan and email to transyouth@fenwayhealth.org	**Fax to** 857-422-4816	

Address	city	state	zip
142 Berkeley St	Boston	MA	02116