GENDER AFFIRMING SURGERY LETTER

Provider Name: _____ License Number: _____

Provider Address: _____

Provider Phone: _____

Patient Information:

Full Name: _____

Date of Birth: _____

Address: _____

Letter Purpose and Medical Necessity:

This letter confirms that the above-named patient has been under my care, and after a thorough evaluation, I have determined that Gender Affirming Surgery is medically necessary for the treatment of gender dysphoria. The patient has demonstrated persistent, well-documented gender dysphoria consistent with recognized diagnostic criteria and has undergone appropriate mental health assessment and real-life experience as indicated in established standards of care. This treatment is intended to alleviate significant distress and improve the patient's overall health, well-being, and quality of life.

Clinical History and Diagnosis:

The patient has a documented history of gender dysphoria as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), including persistent identification with a gender different from the sex assigned at birth, clinically significant distress, or impairment in social, occupational, or other important areas of functioning. The patient has met diagnostic criteria for Gender Dysphoria and has undergone comprehensive evaluation by qualified healthcare professionals.

Treatment Plan and Recommendations:

It is my professional recommendation that the patient proceed with Gender Affirming Surgery appropriate to their therapeutic goals. This may include, but is not limited to, genital reconstruction, chest surgery, facial feminization or masculinization, and other procedures consistent with the standards of care as defined by the World Professional Association for Transgender Health (WPATH). The patient has been provided with counseling regarding the risks, benefits, and expected outcomes of surgery.

Informed Consent and Compliance:

The patient has provided informed consent for the recommended surgeries after a thorough discussion of potential benefits, risks, complications, and alternatives. The patient understands and accepts the possible outcomes and limitations. This recommendation is compliant with applicable state and federal laws, ethical guidelines, and professional standards.

Provider Statement and Signature:

I certify that the information contained in this letter is accurate and complete to the best of my knowledge. I am a licensed healthcare provider qualified to make this medical determination and recommendation. This letter is intended to support the patient's access to medically necessary surgical care and related insurance coverage.

Provider Signature: _____

Date: _____

Provider Name (Printed): _____

Provider License Number: _____

PROVIDER SIGNATURE

Signature: _____