SAMPLE MEDICAL PROVIDER LETTER

(ON LETTERHEAD)

(Date)
Re: **(patient's legal name and preferred name)**
(Date of birth)

Dear Dr. **(name):**

I am writing on behalf of my patient **(legal name, preferred name, and date of birth),** who uses **(pronouns)**, whom I would like to refer for gender affirmation surgery **(chest reconstruction or breast augmentation)**. **(Patient preferred name)** has been my patient for **(# years)** at **(practice name).**

[They have socially transitioned by [list how - change name, pronoun, dress, make-up, hair, tuck, pack, binding, coming out etc). They have been successfully and consistently living in a gender role congruent with their affirmed gender since [date]. They have been consistently on hormone therapy since [date] (If contraindicated or chosen not to take hormones, state that here). Despite, these interventions, they report significant anxiety, depression, and distress due to their experience of dysphoria. By my independent evaluation of [patient name], I diagnosed them with Gender Dysphoria (ICD-10 F64.1). They have expressed a persistent desire for [surgery]. Their goals of surgery are [goals]. Surgery will address their gender dysphoria in these ways: [explain].

(Patient preferred name) identifies as **(gender)** both socially and psychologically. **(Patient preferred name)** notes they have knew their gender identity differed from their assigned sex at birth at **(age). (Pronoun)** has been living life fully and openly as **(gender)** for **(x amount of time).** They have socially transition by **(list – change name, pronoun, dress, hair, binding, etc).** Despite these interventions,

(Patient preferred name) continues to experience significant emotional distress due to **(pronouns used)** body not fully aligning with **(identified gender identity)**. It is my professional opinion that in this way, **(patient preferred name)** meets the criteria for having gender dysphoria (ICD 10: F64.1) and meets the Diagnostic and Statistical Manual of Mental Disorders 5 Edition criteria.

If undergoing hormone therapy include this section (if not disregard)
(Patient preferred name) presents full times as **(identified sex/gender)** and has had a positive experience with **(feminization/masculinization**) through hormone therapy since **(date)**.

Having gender affirmation **(chest reconstruction or breast augmentation)** surgery is the next appropriate step to enable **(patient preferred name)** to continue living as **(gender)** the role in which **(pronouns used)** most comfortably and effectively function.

(Patient preferred name) has demonstrated an understanding of the permanence, costs, recovery time, and possible complications of this surgical gender affirmation surgery and is fully capable of making an informed decision about surgery. (**Patient preferred name**) is reasonably expected to follow pre and post-surgical treatment recommendations responsibility.

It is my opinion that **(patient preferred name)** is emotionally and practically ready for this surgery provided you find **(pronoun used)** medically fit. It you would like to discuss this in more detail, please call me at **(telephone number).**

Sincerely,

Physical signature must be included

(provider name), (credentials)