ADVOCATES FOR TRANS EQUALITY

Trans Health Project

Working for Transgender Equal Rights

Breast augmentation for gender dysphoria - Hormone provider or surgeon checklist

Use this checklist to ensure that each element is included in your letter. Use language that is client specific; do not simply copy this checklist.

Identification of the procedure and diagnosis

☐ The duration of the provider's relationship with the patient
☐ That the patient has gender dysphoria
☐ Procedure needed

Hormone use

☐ What hormone therapy the patient is on
☐ Date started and length of time on hormones
☐ That the patient takes the hormones consistently and appropriately
☐ WPATH SOC p. 59 states: "Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results." If the patient has not had 12 months of hormone therapy, explain why a delay would either likely not result in additional growth (e.g., due to age) and/or would exacerbate the patient's gender dysphoria. Or if hormones are not appropriate for the person at all, explain why that is clinically appropriate for that person due to gender goals or medical contraindication.

Chest dysphoria

☐ That the patient has had insufficient breast growth to alleviate her gender dysphoria
☐ Any complaints that the patient has stated about the size and shape of her of current breasts, misgendering, clothing, etc.
☐ If breasts are atypical for a female, describe, e.g., size, Tanner stage, more like male gynecomastia (breast mass concentrated closer to the nipple);
☐ Reference to size of the torso if the breasts are disproportionately small compared to her overall body.

Capacity to make a fully informed decision and to consent for treatment

☐ Patient has capacity to make a fully informed decision
☐ Patient has provided informed consent for surgery (if you have discussed it with them)

Statement of medical necessity

- ☐ Explain that WPATH criteria for surgery (p. 59) have been met.
- ☐ Indicate if you recommend surgery
- ☐ If you find it to be accurate, use the phrase “medically necessary,” which is defined in insurance policies simply to mean clinically appropriate care to treat a condition in accordance with generally recognized standards of care
- ☐ Indicate if the surgery is undertaken for the purpose of treating gender dysphoria and will help to alleviate the person’s gender dysphoria
- ☐ If you have seen this surgery help other trans patients, note that

State the qualifications of the provider

Discuss your credentials as applicable. Omit things that do not apply.

- ☐ Education and degree
- ☐ Licensure
- ☐ Length of time & experience working with/diagnosing trans patients
- ☐ Number/percentage of trans patients seen, if a significant part of your practice
- ☐ Continuing education in the assessment and treatment of gender dysphoria;
- ☐ Relevant professional associations
- ☐ Relevant publications
- ☐ Relevant trainings given, courses taught
- ☐ Consider attaching CV if a specialist

If you need any additional information, please do not hesitate to contact me at [phone].

Sincerely,

Signature
Provider’s Name
Licensing information
