Trans Health Project

Working for Transgender Equal Rights

Minor Puberty Blockers / Hormone Replacement Therapy

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 patient and diagnosis

☐ The client's general identifying characteristics (age, gender, etc.)
☐ The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date
☐ Results of the client's psychosocial assessment, including any diagnoses

Statement of Medical Necessity

☐ Explain that WPATH criteria for hormones have been met. (p. S258, Appendix D of WPATH SOC v8, available here) Address each point of the WPATH Criteria:
  ☐ Gender diversity/incongruence is marked and sustained over time
  ☐ Meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access health care
  ☐ Demonstrates the emotional and cognitive maturity required to provide informed consent/ assent for the treatment
  ☐ Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally.
  ☐ Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility
  ☐ Reached Tanner stage 2
☐ Indicate you recommend initiating puberty blockers / hormone replacement therapy.
☐ Use the phrase "medically necessary," which is generally defined in insurance policies simply to mean clinically appropriate care to treat a condition in accordance with generally recognized standards of care
☐ Note harms associated with withholding or delaying puberty blockers / hormone replacement therapy
☐ If there has been involvement of parent(s)/guardian(s) in the assessment process, note that, **unless their involvement is determined to be harmful to the adolescent or not feasible**

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
