



# Trans Health Project

*Working for Transgender Equal Rights*

## Minor Surgery Checklist

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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 client's general identifying characteristics (age, gender, etc.)
- The duration of the provider's relationship with the patient
- That the patient has gender dysphoria
- Procedure needed

### Procedure-Specific Dysphoria & Related Complaints

- Include a narrative of gender dysphoria symptoms generally, and those that specifically relate to the procedure in question.
- Any complaints of how gender dysphoria impedes their ability to perform activities of daily life
- Any steps they have taken to alleviate gender dysphoria, such as chest binding
- Harms associated with not having or delaying surgery
  - Example: Top surgery
    - Chest dysphoria
    - Binding, problems associated with binding
    - Long-standing desire for surgery

## Statement of medical necessity

- Explain that WPATH criteria for surgery 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
  - At least 12 months of gender-affirming hormone therapy or longer, if required, to achieve the desired surgical result for gender-affirming procedures, including breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery as part of gender-affirming treatment unless hormone therapy is either not desired or is medically contraindicated
- Indicate you recommend surgery
- 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
- 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
- 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

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