Minor Surgery 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 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

If you find this helpful, please consider making a donation at https://transgenderlegaldefense.networkforgood.com to support our work.
