

## Required Letter Information

Please Print

Your Name: \_\_\_\_\_ Date: \_\_\_\_\_

Your Phone Number: \_\_\_\_\_ Your email: \_\_\_\_\_

Where you would like me to send the letter:

Individuals Name: \_\_\_\_\_

Name of Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Country: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Email: \_\_\_\_\_

Office Contact (if applicable): \_\_\_\_\_

Purpose of Letter: \_\_\_\_\_

\_\_\_\_\_

Information that you specifically want included:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date you would like this person to receive the letter: \_\_\_\_\_

Any other information you would like me to know regarding this letter:

\_\_\_\_\_

You can bring this to me or fax to 713-862-9121. Thank you.

Letters for SRS: MtoF  
(Additional Information)

**Psychotherapy:**

Therapist with whom you've done your transitioning work.

When: \_\_\_\_\_

Where: \_\_\_\_\_

With Who: \_\_\_\_\_

If you've had more than one therapist.

When: \_\_\_\_\_

Where: \_\_\_\_\_

With Whom: \_\_\_\_\_

**Laser Hair Removal:**

When: \_\_\_\_\_

Where: \_\_\_\_\_

With Whom: \_\_\_\_\_

**Electrolysis:**

When: \_\_\_\_\_

Where: \_\_\_\_\_

With Whom: \_\_\_\_\_

**Name and Gender change:**

Date the change was granted: \_\_\_\_\_

Where: (give state) \_\_\_\_\_ (County) \_\_\_\_\_

Attorney: \_\_\_\_\_

**Hormones:**

When did you begin hormones? \_\_\_\_\_

How long have you been on hormones? \_\_\_\_\_

M.D who presently prescribes for you: \_\_\_\_\_

Is this doctor an endocrinologist, general practitioner, internal medicine physician  
Gynecologist or other? (Please state) \_\_\_\_\_

**Facial Feminization:** (if applicable)

When: \_\_\_\_\_

Procedures you have had: \_\_\_\_\_

Surgeon's name: \_\_\_\_\_

Address: \_\_\_\_\_

If more than one facial surgery:

When: \_\_\_\_\_

Procedures you have had: \_\_\_\_\_

Surgeon's name: \_\_\_\_\_

Address: \_\_\_\_\_

**Voice Coaching** (if applicable)

When: \_\_\_\_\_

Name of Voice Coach: \_\_\_\_\_

Address: \_\_\_\_\_

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Do you presently have any significant medical conditions? \_\_\_\_\_

Are you taking any medication on a regular basis? \_\_\_\_\_

I have been living full-time since: \_\_\_\_\_

I have transitioned on my job: yes \_\_\_\_\_ no \_\_\_\_\_

Place of employment where you transitioned: \_\_\_\_\_

Where will you be working after your surgery? : old job \_\_\_\_\_ new job \_\_\_\_\_

Where will you be working? \_\_\_\_\_

Job title: \_\_\_\_\_

After surgery, I will be working: full-time \_\_\_\_\_ part-time \_\_\_\_\_ n/a \_\_\_\_\_

After surgery, I will be a student: full time \_\_\_\_\_ part-time \_\_\_\_\_ n/a \_\_\_\_\_

I can financially support myself: yes\_\_\_\_\_ no: \_\_\_\_\_

Date of divorce: (if applicable) \_\_\_\_\_

My immediate biological family is supportive of my surgery.

Yes: \_\_\_\_\_ No: \_\_\_\_\_

I have a good network of friends who give me emotional support and accept me and the changes I have made. Yes\_\_\_\_\_ No \_\_\_\_\_

I am active in the transgender community. Yes \_\_\_\_\_ No \_\_\_\_\_

Who will be writing the second letter you need for your surgery?

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Any other significant information that you would like me to know or include in your letter supporting you for SRS?

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You may bring this to me, email to [deniseod@aol.com](mailto:deniseod@aol.com), or fax to 713-862-4585

Thank you.