Letter for Top Surgery and Consent
FtoM

Current Legal Name: _____

Choosen Name: _____

Today's Date: _____

Your Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Work Phone: _____

Email: _____ Home Phone: _____

Date of Birth: _____ SS # - _____

****

Name of the surgeon you have chosen to do surgery: _____

Address of surgeon: _____

_____

Doctor's Phone number: _____

Doctor's Fax number: _____

Doctors contact Person: _____

Date of your scheduled surgery: _____

Date you would like this letter to go to your surgeon: _____

If applicable, who will be writing a second letter / assessment for your surgery?

Name: _____
Title: _____
Address: _____
Relationship to you: _____

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

_____

_____

_____

Psychotherapy:

Therapists with whom you've done your transitioning work.

When: _____
Where: _____
With Who:_____

If you've had more than one therapist.

When: _____
Where: _____
With Whom: _____

Name and Gender change: (if applicable)

Date the change was granted: _____

Where: (give state) _____ (County) _____

If applicable, who was the attorney who assisted you? _____

Testosterone: (if applicable)

When did you begin testosterone? _____

How long have you been on testosterone? _____

M.D who presently prescribes for you: _____

Is the doctor who prescribes your testosterone an endocrinologist, general practitioner, internal medicine physician, gynecologist or other? _____

Do you presently have any significant medical conditions?

_____

_____

_____

Are you taking any medication on a regular basis?
(please list with how often you take them and the amounts)

_____
_____
_____
_____

I have been living full-time since: _____

Where do you work presently? _____

Do you cross dress at work? _____

How long have you been there? _____

What is your job title? _____

Will you be maintaining your present job after you transition? yes _____no _____

If not, where will you be working after your surgery? : _____

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 _____

If retired, how long have you been retired: _____

I can financially support myself: yes_____ no: _____

Present Marital Status: _____

Names and ages of children: (if applicable) _____

_____

Do your children know of your plans to have this surgery? Please give names and ages in the yes or no category.

Yes- _____ No- _____

Date of any past divorces: (if applicable) _____

Who in your immediate biological family is supportive of your surgery?

_____
_____
_____
_____

Who in your immediate biological family is not supportive of your surgery?

_____
_____
_____

I have a good network of friends who give me emotional support, accept me and support my transition. Yes_____ No _____

This network of friends consists of approximately _____ people.

The following people / person will be accompanying me to surgery and will be included in my post surgery care:

_____

_____

_____

Please list any Civic, Social, Professional Organizations where you are a member or attend regularly.

_____

_____

_____

I am active in the transgender community. Yes _____ No _____

If so, what do you do in the transgender community?

_____
_____
_____
_____

If applicable, who will be writing a second letter / assessment for your surgery?

Name: _____
Title: _____
Address: _____
Relationship to you: _____

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

_____

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_____

_____

Why have you chosen to have surgery at this particular time?

_____

_____

_____

_____

_____

_____

What is your current rationale for having surgery?

In your opinion, what effect would it have on your life, if surgery were not an option.

By signing this document below, I am giving my informed consent that I am psychologically and practically prepared to have sexual reassignment surgery and, in addition, I am requesting a letter by Denise O'Doherty LPC MSN in support of my decision, to be sent to my surgeon.

Name: _____

Date: _____