DATE

To Whom It May Concern:

This letter contains my strong endorsement for [LEGAL FIRST LASTNAME], also known as [CHOSEN FIRST LAST NAME], [DOB] decision to undergo gender-affirming [SURGERY TYPE].

I am a \*\*\*[LICENSED MENTAL HEALTH PROVIDER] [LICSW/LMHC/LASW/LMFT/PSYCHIATRIST/PSYCHOLOGIST/PSYCHIATRIC ARNP/PMHNP-BS ] and have been seeing [CHOSEN NAME] [FREQUENCY OF VISITS] since [MONTH YEAR] after [PRONOUNS] sought my services to help [CHOSEN NAME] cope with Gender Dysphoria.

**ASSOCIATE LEVEL MENTAL HEALTH PROVIDERS MAY AUTHOR LETTER AND INCLUDE SIGNATURE AND ADDENDUMN FROM SUPERVISOR EMBEDDED IN THE ASSOCIATE LEVEL PROVIDER’S LETTER SIGNATURES SHOULD BE ON THE SAME PAGE**

During a comprehensive psychosocial assessment, I learned that [CHOSEN NAME] has had consistent and persistent gender dysphoria since [AGE], yet did not have the language to understand [PRONOUNS] as transgender until [PRONOUNS] was about [XX] years old. [CHOSEN NAME] came out to [PRONOUNS ] parents and community and made a social gender transition [AGE OR LIFE EVENT]. [PRONOUNS] symptoms do meet DSM-5 criteria for a Gender Dysphoria diagnosis, and [PRONOUNS] has been living in [AFFIRMED GENDER IDENTITY] for [X] [MONTHS/YEARS].

[CHOSEN NAME] has been evaluated for coexisting mental health diagnoses and **{*choose which applies*}** Does not present with any mental health conditions outside of Gender Dysphoria. **OR** Presents with [COEXISTING MENTAL HEALTH DIAGNOSES] which is/are adequately managed.} [CHOSEN NAME] is emotionally stable, and is intellectually able to make an informed decision to undergo [SURGERY TYPE]. I strongly recommend [SURGERY TYPE] to alleviate [CHOSEN NAME]’s Gender Dysphoria.

*Optional if appropriate*: {Since [CHOSEN NAME] has chosen not to pursue hormone therapy at this time, [SURGERY TYPE] is even more important to increasing [PRONOUNS] safety and ability to pass as [PRONOUNS] affirmed gender.} [CHOSEN NAME] [INFORMATION ABOUT FAMILY AND SUPPORT NETWORK/POST-SURGICAL SUPPORTS].

[include WPATH standards of care in letter, these are surgery specific]

**{Chest /breast surgery}** According to the World Professional Association for Transgender Health (WPATH) Standards of Care, Version 7, criteria for gender affirming surgery include: 1. persistent, well-documented gender dysphoria; 2. capacity to make a fully informed decision and to consent for treatment; 3. age of majority in a given country; 4. insignificant or well-controlled medical or mental health concerns. . [CHOSEN NAME] easily meets these criteria, and is a strong candidate for [SURGERY TYPE].

**{Hysterectomy / Ovariectomy / Orchiectomy}** According to the World Professional Association for Transgender Health (WPATH) Standards of Care, Version 7, criteria for gender affirming surgery include: 1. persistent, well-documented gender dysphoria; 2. capacity to make a fully informed decision and to consent for treatment; 3. age of majority in a given country; 4. insignificant or well-controlled medical or mental health concerns; 5. 12 continuous months of hormone therapy. [CHOSEN NAME] easily meets these criteria, and is a strong candidate for [SURGERY TYPE].

**{Metoidioplasty/ Phalloplasty/ Vaginoplasty}** According to the World Professional Association for Transgender Health (WPATH) Standards of Care, Version 7, criteria for gender affirming surgery include: 1. persistent, well-documented gender dysphoria; 2. capacity to make a fully informed decision and to consent for treatment; 3. age of majority in a given country; 4. insignificant or well-controlled medical or mental health concerns; 5. 12 continuous months of hormone therapy; and 6. 12 continuous months of living in a gender role that is congruent with gender identity. [CHOSEN NAME] easily meets these criteria and is a strong candidate for [SURGERY TYPE].

I am available for consultation and coordination of care and welcome phone calls to establish this upon a release of information from my client.

Sincerely,

[WET SIGNATURE]

PROVIDER NAME, CREDENTIALS

PROVIDER CONTACT INFO

**SUPERVISOR ADDENDUM**

I am the supervisor of [ PATIENT CHOSEN NAME]’s therapist [ASSOCIATE LEVEL THERAPIST NAME]. I agree with the assessment and diagnosis of gender dysphoria.

Sincerely,

[WET SIGNATURE]

SUPERVISOR NAME, CREDENTIALS

CONTACT INFO