



TRANS AND GENDER-AFFIRMING CARE **in IHS/Tribal/Urban Facilities:** **2020 Strategic Vision and Action Plan**

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STATEMENT OF INTENT

Note: We are aware that terminology is quickly changing and varies regionally and culturally. In this document, we use the phrase 'gender-diverse' to refer to Two Spirit, trans, genderqueer, nonbinary, agender, and other patients with gender identities other than cisgender. We include all identities and gendered ways of being held by Indigenous persons beyond the colonial gender binary. We use the term Indigenous where possible to refer to the original peoples of the Americas; however, we also use "Native" or "Indian" when referencing institutions like the Indian Health Service.



Since time immemorial, Indigenous cultures have appreciated complex and numerous concepts of gender identity. Occupation and settlement of North America by Europeans, however, violently interrupted the systems that supported much of that traditional diversity and acceptance. Today, Indigenous people who do not identify as cisgender face discrimination in workplaces, education centers, and healthcare settings (to name a few). In 2014, 37% of Indigenous transgender people postponed necessary medical care because they feared mistreatment as a transgender person. Of those who did access care, 50% reported having at least one negative experience related to their transgender identity. These experiences include refusal of gender-affirming care, having to educate providers about that care, and learning of the unavailability of gender-affirming care at their clinic.¹ The disparities faced by gender-diverse individuals, including increased levels of depression and anxiety, can be greatly minimized by reducing barriers to access of healthcare and by ensuring gender-diverse people are affirmed in their gender identities. Simply using a person's correct name and pronoun has been associated with a 65% decrease in suicidal thoughts in gender-diverse youth.²

Gender-affirming care refers to healthcare that affirms a person's gender identity and allows gender-diverse people to live more authentically. To be gender-affirming, providers must create positive and optimistic medical care systems, inclusive clinic environments, and patient support through effective and compassionate social gender transition. With appropriate planning and support, gender-affirming healthcare can be highly successful at all levels of the medical system, including primary care, behavioral health care, pharmaceutical care, Indigenous medicine, and various other specialties. If effectively applied, gender-affirming care becomes integrated throughout all clinical services. Incorporating holistic and affirming care with respect to both gender and culture, and welcoming clinical spaces for all patients ensures gender-diverse patients have access to the care they medically need and that they feel safe accessing that care.

¹ 2015 U.S. Transgender Survey: Report on the Experiences of American Indian and Alaska Native Respondents. National Center for Transgender Equality (2015): <https://transequality.org/sites/default/files/docs/usts/USTS-AIAN-Report-Dec17.pdf>

² Russell ST, Pollitt AM, Li G, Grossman AH. Chosen Name Use Is Linked to Reduced Depressive Symptoms, Suicidal Ideation, and Suicidal Behavior Among Transgender Youth. *J Adolesc Health*. 2018;63(4):503-505. doi:10.1016/j.jadohealth.2018.02.003

STATEMENT OF INTENT *CONTINUED*

This strategic plan supports the Indian Health Service (IHS), tribal, and urban Indian clinics (I/T/U) as they begin to provide gender-affirming care to their patients by emphasizing the following four goals:

1. Develop and pass protective policies at the federal, tribal, and local levels;
2. Ensure affirming clinical environments for gender-diverse patients;
3. Ensure best practice care for Indigenous gender-diverse patients; and
4. Improve I/T/U health systems support for initiatives focused on the wellness of gender-diverse community members.

These recommendations are not individual-level interventions. They are structural and community-level interventions to ensure the wellbeing of gender-diverse patients. We hope that the Northwest Portland Area Indian Health Board (NPAIHB), the various tribal nations in the Pacific Northwest, and partnering agencies use this plan to guide program planning, catalyze community outreach efforts, and foster a coordinated response to the health and wellbeing of gender-diverse members of our tribal communities.

The Native Advocacy Workgroup for Trans Health will work to annually revise and implement the policies of this strategic visioning document.

Note: We have focused here on support for gender-affirming initiatives. However, we realize many of these supports, including funding and trainings will also broadly address Two Spirit and LGBTQ+ health. We also recognize that recommendations put forth in this strategic plan could be adapted by non-healthcare organizations, including academic, social service, political, and business institutions. We consider commitments to features presented in this plan to be important for a wide spectrum of organizations seeking to serve better Indigenous gender-diverse individuals.

TABLE OF CONTENTS

6	Guiding Principles
8	Policy
10	Best Practice Care for Gender-diverse Patients
14	Ensuring Affirming Physical Environments
15	IHS/Tribal/Urban Systems Support
16	Potential Partners
17	Appendix A: Example Clinic Nondiscrimination Policy
24	Appendix B: Example Tribal ID Documents
26	Appendix C: Example Guidelines for Gender-Affirming Care
27	Appendix D: Example Organ Inventory in EHR
28	Appendix E: Sample Questions for Intake Forms
30	Appendix F: Sample Consent Forms for Hormone Therapy
46	Appendix G: Sample Protocol for Hormone Prescription

GUIDING PRINCIPLES

The authors created the strategies and action plans outlined in this document with the following priorities and perspectives. These principles are upheld throughout this work:

Indigenous understandings and practices are integrated. Prior to colonization, Indigenous cultures and communities had diverse concepts of gender, many of which were accepting of—or in some cases required—a wide array of gender diversity. We center these diverse Indigenous concepts of gender identity and de-center the compulsory binary gender embedded in colonial culture in the following ways:

- We do not assume that a person identifies with their assigned sex at birth and do not assume a person seeking gender-affirming care wishes to “pass” as a gender opposing their assigned sex at birth.
- We recognize that some within our communities are also intersex, and we do not assume that sex assigned at birth is always binary, clear, or accurate.
- We do not assume all individuals use consistent pronouns or use pronouns at all. We recognize pronouns are themselves a construction of the colonizer’s language.
- We recognize gender as “the mental, emotional, and social aspects of one’s expression and identity rather than an individual’s physical or biological makeup.”³ We prioritize healthcare that takes this holistic approach and emphasizes supporting an individual’s authentic self-expression, and in many cases, social transition.
- We strongly encourage the integration of Indigenous healing practices in clinical settings. We also strongly encourage support for gender-diverse practitioners to provide these services.

Initiatives are led by gender-diverse people. Any initiative aimed at improving the clinical experiences and wellness of gender-diverse individuals must necessarily include those voices and individuals not only as consultants but in compensated, leadership roles. Current gender-diverse-inclusive initiatives include the following:

- The Native Advocacy Workgroup for Trans Health and the IHS LGBTQ2S Workgroup is involved in the creation, review, and implementation of this document.
- One initial step in this plan is the creation of a Gender-Affirming Care Advisory Council, including clinicians, community members, and youth which will serve to interpret and guide the work done in response to this plan.

³ <http://keinfoSHOP.org/zines/settler-sexuality.htm>

GUIDING PRINCIPLES CONTINUED

Initiatives recognize Indigenous diversity in gender concepts, roles, and practices. This work begins with the recognition that tribes have always had diverse cultures, histories, and varied gender identity concepts, each of which also has had a unique history of colonization and has been altered in specific ways. There are also diverse historical and contemporary manifestations of acceptance of gender-diverse tribal members in various tribal nations and communities. Our recognition of tribal diversity includes:

- Offering sample policies for tribes to adapt as their needs demand.
- Creating protections for gender-diverse community members at the federal, state, and tribal levels.
- Identification of cultural leaders and wisdom/story-keepers to advise implementation of recommendations outlined in this document.



POLICY

Legislative and policy initiatives are needed to protect basic rights and access to comprehensive healthcare for gender-diverse community members and patients. This protection should include nondiscrimination policies that ensure healthcare access for all people regardless of gender identity or sexual orientation and the clinical adoption of best-practice guidelines for care, which provide access to quality healthcare for gender-diverse people. Listed below are existing and desirable policies at the clinical, tribal, state, and federal levels to aid in, assist with, and guarantee protections for gender-diverse individuals.

EXISTING POLICIES

Tribal Organizations

POLICY	ORGANIZATION	YEAR
<u>Standing in Support of our Two Spirit Relatives in our Communities and Nations</u>	National Congress of American Indians 2015	2015
<u>Support for Quality Care and Improved Health Outcomes for Two Spirit and LGBTQ+ People</u>	National Congress of American Indians; Affiliated Tribes of Northwest Indians; Northwest Portland Area Indian Health Board	2020
<u>In Support of Native Students, Educators, and Community Members who Identify as LGBTQ2S</u>	National Indian Education	2019

Tribal Policies

POLICY	TRIBE	YEAR
<u>Hate Crimes Law Inclusive of Sexual Orientation and Gender Identity</u>	Oglala Sioux	2020
<u>Proclamation Establishing June as Pride Awareness Month</u>	Tohono O'odham	2020
Same-sex Inclusive Marriage Laws	Lummi Nation (Note: Here is a list of same-sex marriage laws by tribe)	2019
Gender-Affirming Tribal ID Documents (Appendix B)	Confederated Tribes of Siletz Indians	2019

POLICY CONTINUED

Federal Policies

POLICY	YEAR	RELEVANT EXCERPT
<u>Title VII – Civil Rights Act;</u> <u>IHS Policy Interpretation</u>	1964; Includes sexual orientation and gender identity, by rule of Supreme Court in 2020.	"Title VII prohibits employment discrimination based on race, color, religion, sex and national origin."
<u>Affordable Care Act</u>	2010	"Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities."

State Policies

Please visit [Movement Advancement Project](#) for a map of nondiscrimination policies by state.

DESIRABLE POLICIES

Tribal Resolutions:

1. Nondiscrimination Ordinance (See [Tribal Equity Toolkit 3.0](#))
2. Support for Quality Healthcare for Gender-Diverse People
3. [Gender-Affirming ID Documents & Enrollment Cards](#)

Clinic Guidelines and Statements:

1. Posted Nondiscrimination Statement: *"It is the policy of [Clinic Name] to treat all patients and not to discriminate with regard to race, religion, national origin, age, sex, **sexual orientation, gender identity** or expression, or disability."*
2. [Nondiscrimination Policy Including Sexual Orientation and Gender Identity](#)
3. [Best Practice Guidelines and Protocols for Trans & Gender-affirming Care](#)
4. Guidelines for SOGI Data Collection (See [Guidelines from Fenway Institute](#))

Federal Policies:

1. IHS Nondiscrimination Policy
Progress: Leadership briefing with Office of Management Services at IHS
2. IHS Guidelines and Protocols for Trans & Gender-affirming Care
Progress: Leadership briefing with Office of Management Services at IHS
3. IHS SOGI Data Collection Policy
Progress: Expect federal policy by December 2020.

BEST PRACTICE CARE FOR GENDER-DIVERSE PATIENTS

The University of California, San Francisco (UCSF), the Endocrine Society and the American Academy of Pediatrics developed guidelines that equip primary care providers and health systems with the tools and knowledge needed to meet the healthcare needs of gender-diverse patients. These best practice guidelines, developed in consultation with a medical advisory board, are updated regularly to reflect the most recent medical research and evolving best practices.

These guidelines include, but are not limited to, the following:

- recommendations for creating a safe and welcoming clinical environment;
- recommendations for physical examination of gender-diverse people;
- recommendations for prescribing femininizing and masculinizing hormone therapy;
- sexual and mental health considerations for gender-diverse people;
- recommendations for supporting a patient's social transition, including voice therapy, identity documents, and health insurance; and
- recommendations for gender-affirming surgical procedures and aftercare.

Any clinic can implement these guidelines, and they are appropriate for all clinic environments, including primary care, reproductive healthcare, behavioral healthcare, pharmacy, emergency departments, and other specialties. By following these guidelines, a clinic ensures the care it offers is in keeping with current best practices and remains updated as those practices continue to develop.

In addition to adopting these best practice guidelines, I/T/U clinics can implement the suggestions on the following page to best support gender-diverse patients.

Note: None of the above guidelines are specifically designed for Indigenous communities. They should be adapted to integrate cultural practices and Indigenous medicine.

⁴ <https://transcare.ucsf.edu/welcome>

⁵ <https://www.endocrine.org/clinical-practice-guidelines/gender-dysphoria-gender-incongruence>

⁶ <https://pediatrics.aappublications.org/content/142/4/e20182162>

BEST PRACTICE CARE FOR GENDER-DIVERSE PATIENTS *CONTINUED*

1. Clinical provider applies the latest electronic health records (EHR) solutions to meet the needs of gender-diverse patients.

- Include pronoun and name markers on patient records;
- Document organ inventory within patient records; and
- Implement appropriate screening guidelines based on organ inventory

Note: Roll out of SOGI-inclusive EHR in IHS beginning September 2020.

2. Provide culturally-attuned care to all Indigenous patients.

- Offer Indigenous medicine and culturally-specific services;
- Integrate these services into existing clinical services whenever possible;
- Ensure these practices are treated with parity alongside colonial medicine;
- Ensure patients can access Indigenous medicine services;
- Advocate for sustainable mechanisms to provide adequate pay to Indigenous cultural practitioners, whether through insurer reimbursement, revenue, or other sources not reliant on grants and without undue burden on the practitioners; and
- Provide culturally-attuned group- and community-level interventions such as the talking circle or sweat lodge, for gender-diverse youth and adults.
- Ensure providers of Indigenous medicine are trained in trauma-informed care.

3. Provide access to gender-affirming surgery and procedures directly or indirectly through clear, pre-screen referrals.

- Provide clear and transparent guidelines to patients regarding necessary documentation needed to access such treatments at the outset;
- Ensure that no patient is turned away or denied access based on ability to pay;
- Work to educate providers and purchase-and-referred care (PRC) specialists to create guidelines for gender-affirming care to be provided outside of the IHS/tribal system;
- Provide patients with guidelines to cover expenses for gender-affirming surgery;
- Provide access to an endocrinologist for hormone therapy in preparation for gender-affirming surgery;
- Protect reproductive sovereignty for gender-diverse patients; and
- Provide legal and social support services for gender-diverse youth, especially minors, who may struggle to have conversations about gender-affirming care with their parents and providers, or who may require other additional assistance related to social or legal support for transition.

BEST PRACTICE CARE FOR GENDER-DIVERSE PATIENTS *CONTINUED*

4. Routinely collect aggregate data on sexual orientation and gender identity (SOGI) and conduct meaningful analysis of that data for all patients.

- Include sexual orientation and gender identity fields on patient intake forms;
- Integrate these measures into clinical EHR;
- Ensure SOGI information capture is appropriate for youth of different ages;
- Train clinical providers to discuss SOGI during clinic visits when relevant to improve patient care and experience; and
- Create resource lists for front line staff with policies for legal name change and other non-medical transition-related services where available.

5. Ensure commitment to gender-affirming care within the patient pharmacy.

- Ensure a variety of gender-affirming medications are available on clinic pharmacy formulary to allow for patient choice;
- Integrate pharmacist into team of gender-affirming care clinicians;
- Advocate for gender-affirming medications to be included on national core formulary explicitly for gender-affirming use; and
- Ensure pharmacy staff use clients' correct names and pronouns when dispensing medication.

6. Ensure commitment to gender-affirming behavioral health care.

- Provide patient access to therapists, psychologists, and counselors with experience working with both Indigenous and gender-diverse patients;
- Ensure access to strengths-based behavioral health care for gender-diverse youth; and
- Initiate behavioral health referrals to gender-affirming providers as needed.

7. Foster a clear understanding of the clinic's abilities to provide competent gender-affirming care as well as its current limitations, and be transparent with patients about each.

- Support the free-flow of information about the current and pending status of national, state, and tribal policies;
- Publish protocols for I/T/U gender-affirming care and make those present and accessible within the clinic by request;
- Establish vetted referrals for services not currently provided within the clinic; and
- Be transparent about the specific limitations a clinic or provider may face in supporting gender-diverse youth, especially minors.

BEST PRACTICE CARE FOR GENDER-DIVERSE PATIENTS *CONTINUED*

8. Hire and train a patient navigator or social worker to coordinate gender-affirming care within and beyond the healthcare system.

- Support gender-diverse patients to navigate social, emotional, and physical wellness care. This can include finding medical, behavioral health, and other providers, assisting with name change and other legal needs, securing housing or employment, intimate partner violence services, emancipation, etc. (such as a Community Health Representative, Health Aide, or Centers for Medicare/Medicaid re-imbursable position);
- Support gender-diverse youth and their families through pre-pubertal, pubertal, and post-pubertal stages of gender-affirming care; and
- Recruit patient navigators and social workers who reflect the communities they serve.

9. Commit to integration of gender-affirming care across the continuum of clinical services.

- Institute a gender-affirming healthcare team in each clinic (may include primary care provider, endocrinologist, behavioral healthcare provider, front line staff, pharmacist, transitional medicine practitioner, and community health representative);
- Ensure a level of SOGI competency across clinical and human services staff;
- Ensure support for gender-diverse people with other health considerations, including HIV; and
- Integrate non-medical care at each clinic to include:
 - Access to Indigenous, gender-diverse-affirming voice therapists;
 - Access to pro-bono legal services to assist with ID documents, emancipation, and any other legal needs; and
 - Access to Indigenous practitioners with knowledge of the importance of pre-colonial gender systems.

ENSURING AFFIRMING ENVIRONMENTS

To safely and effectively access healthcare, gender-diverse patients need clinical environments in which they feel safe and accepted. Clinicians or medical directors are encouraged to take a quick survey to determine how affirming their clinic is for gender-diverse patients.

Based on a clinic's survey result, clinicians and/or medical directors can then use this online tool to identify actionable steps that will improve their clinic environment, making it more affirming for gender-diverse patients.

The Native Advocacy Workgroup for Trans Health will focus on the dissemination and implementation of these tools.

Our next steps are:

- Disseminate the checklist to clinics through regional and national meetings, face-to-face encounters, inclusion in clinical resource lists, and through Project ECHO;
- Ensure clinics can use and implement the suggested strategies by providing free print materials, pronoun buttons, and trainings to clinics;
- Use quality improvement/patient satisfaction surveys to begin to understand the needs of gender-diverse patients at I/T/U clinics (for instance, the IHS Consumer Satisfaction Survey);
- Integrate maintaining an affirming clinic environment into clinic policy;
- Set national and public standards for clinic affirmation.

IHS/TRIBAL/URBAN SYSTEMS SUPPORT

IHS, tribal, and urban Indian clinics need support to implement clinic-level changes in policy, affirming environments, and providing best-practice care. The following list avenues of potential support for I/T/U and partner agencies:

1. Locate grants and funding to support the needs of gender-diverse people.

IHS and partner agencies propose and support grants for gender-diverse health equity, explicitly funding initiatives that support:

- Access to behavioral healthcare for gender-diverse patients;
- Clinical training to create affirming clinic environments;
- Increased capacity of healthcare providers to offer gender-affirming care;
- Identify champion affirmative clinicians in each IHS region;
- Education of gender-diverse populations about medical and preventative care;
- Integration of Indigenous medicine; and
- Data collection to better understand needs of gender-diverse people, youth and adults.

2. Continue to support regular training on gender-affirming environments and care for all clinical staff. Clinical staff include healthcare providers, as well as intake, front-desk, transportation, and security staff.

- Prioritize support for and application of trainings intended to increase awareness of gender diversity and to promote gender-affirming care across the I/T/U system; and
- Include training on insurance access, coverage of gender-affirming care, and appeals.

3. Support the recruitment and retention of mental health providers who have experience with gender-diverse patients, both youth and adults.

- Train providers to provide trauma-informed and strengths/resiliency-focused care; and
- Integrate Indigenous methods of healing.

4. Support access to gender-affirming providers.

- Provide a patient-facing list of gender-affirming and Indigenous-affirming providers.

POTENTIAL PARTNERS

Note: We have deliberately prioritized organizations led by Indigenous and/or gender-diverse people and those which focus on Indigenous gender-diverse communities in the list below.

NATIONAL ORGANIZATIONS:

- National Congress of American Indians
- National Indian Health Board
- National Council of Urban Indian Health
- Association of American Indian Physicians
- National Indian Law Resource Center
- Native American Rights Fund
- Indian Health Service
- Transgender Law Center
- National Minority AIDS Coalition
- Office of Minority Health
- U.S. Department of Veterans Affairs - The Veterans Health Administration
- Health Resources and Services Administration
- The Fenway Institute

REGIONAL ORGANIZATIONS:

- Tribal Epidemiology Centers
- Indigenous Health Boards
- University of California, San Francisco
- Indiana University LGBTQ+ ECHO
- Trans Resource Centers Associated with State Universities

LOCAL AND COMMUNITY ORGANIZATIONS:

- Native Community-Based Non-Profits
- IHS/Tribal/Urban Clinics

APPENDIX A:

EXAMPLE CLINIC NONDISCRIMINATION POLICY

Oklahoma City Indian Clinic

Oklahoma City Indian Clinic Policies and Procedures

LGBTQ2 Non-Discrimination and Transgender Healthcare Rights		
Ownership: Administration		
Applicable Departments: All Departments		
Effective Date: July 27, 2018	Last Review: September 15, 2020	Last Board Review Date: April 25, 2019
Last Policy Revision: July 20, 2018	Approved By: Janice Hixson, MD Chief Medical Officer	Board Approval Date: July 27, 2018
Last Procedure Revision: September 15, 2020	Approved By: Robin Parker Director of Policy Development	Board Approval Not Required
Reference / Regulatory Standard: • AAAHC Chapter 1: A • National Center for Transgender Equality www.transequality.org/know-your-rights/healthcare • The Center of Excellence for Transgender Health (CoE) at the University of California - San Francisco Guidelines for the Primary and Gender - Affirming Care of Transgender and Gender Nonbinary People. http://transhealth.ucsf.edu/trans?page=protocol-00-00 • The Fenway Institute, Boston, MA http://doaskdotell.org/ehr/toolkit/ • Human Rights Campaign www.hrc.org • Section 1557 of the Affordable Care Act (2010)		

APPENDIX A: EXAMPLE CLINIC NONDISCRIMINATION POLICY CONTINUED

Purpose:

Studies have shown that transgender individuals may avoid seeking care due to prior discrimination in a health care setting. Providing a safe, welcoming, and culturally appropriate clinic environment is essential to ensure that transgender and gender diverse people not only seek care, but return for follow-up. Under the Affordable Care Act, it is illegal for any health care provider, health insurance company, health program or organization that receives any federal funding (including accepting Medicare or Medicaid payments for any patients) or is administered by a federal agency to discriminate against anyone because they identify as transgender or because they don't conform to gender stereotypes.

Policy:

Oklahoma City Indian Clinic (OKCIC) will provide a safe, welcoming and culturally appropriate clinical environment that does not discriminate against any person on the basis of gender identity, gender expression, sexual orientation, or transgender status. OKCIC will comply with all federal regulations to protect patient rights. All LGBTQ/Two- Spirit patients will be treated with respect, and according to their gender identity.

OKCIC promotes patient and family-centered care by allowing patients to be accompanied by a visitor(s) of their choice including, but not limited to, a spouse, domestic partner (including a same sex domestic partner), family members, or a friend, for emotional support during the course of their visit, except treatment areas where visitors are generally not allowed (i.e. dental operator). Visitors designated by the patient or health care proxy, where appropriate, do not have to be legally related to the patient and patients are able to withdraw or deny such consent at any time.

Types of Prohibitive Discrimination by Health Care Providers:

It is illegal for health care providers that receive federal money to do any of the following based upon a patient's gender identity:

- Refuse to admit or treat the patient
- Force the patient to have intrusive and unnecessary examinations
- Refuse to provide services that are provided to other patients
- Refuse to treat a patient according to their gender identity, including providing access to restrooms consistent with the patient's gender identity
- Harass or refuse to respond to harassment by staff or other patients
- Refuse to provide counseling, medical advocacy or referrals, or other support services
- Isolate or deprive the patient of human contact, or limit patient participation in social or recreational activities offered to others
- Require the patient to participate in "conversion therapy" for the purpose of changing their gender identity
- Harass, coerce, intimidate, or interfere with the patient's ability to exercise their health care rights
- In every state, most insurance companies aren't allowed to exclude transition-related care

APPENDIX A: EXAMPLE CLINIC NONDISCRIMINATION POLICY CONTINUED

Definitions and Terminology:

OKCIC adopts the following definition of “family” for purposes of clinic-wide visitation policy:

- **Family:** Any person(s) who plays a significant role in an individual’s life. This may include a person(s) not legally related to the individual. Members of “family” include spouses, domestic partners, and both different-sex and same-sex significant others. “Family” includes a minor patient’s parents, regardless of the gender of either parent. Solely for purposes of visitation policy, the concept of parenthood is to be liberally construed without limitation as encompassing legal parents, foster parents, same-sex parents, step-parents, those serving in loco parentis, and other persons operating in caretaker roles.

The following definitions are some commonly encountered terms, based on North American English language use. A detailed discussion of terminology in the context of the great diversity of transgender and gender nonconforming people encountered across cultures and languages is beyond the scope of these guidelines.

- **Cisgender:** A person whose gender identity and assigned sex at birth correspond (i.e. a person who is non-transgender) (cis = same side in Latin).
- **Cross Dresser / Drag Queen / Drag King:** These terms generally refer to those who may wear the clothing of a gender that differs from the sex, which they were assigned at birth for entertainment, self-expression, or sexual pleasure. Some cross dressers and people who dress in drag may exhibit an overlap with components of a transgender identity. The term transvestite is no longer used in the English language and is considered pejorative.
- **Cross-Sex Hormone Therapy:** The administration of hormones for those who wish to match their physical secondary sex characteristics to their gender identity.
- **Disorders of Sex Development (DSD):** Group of rare conditions where the reproductive organs and genitals do not develop as expected. Some DSDs include Klinefelter Syndrome and Androgen Sensitivity Syndrome. Sometimes called differences of sex development. Some prefer to use the term intersex.
- **Gender Affirming Surgery (GAS):** Surgeries used to modify one’s body to be more congruent with one’s gender identity. Also referred to as sex reassignment surgery (SRS) or gender confirming surgery (GCS). “Bottom surgery” is a colloquial way of describing gender affirming genital surgery
- **Gender Dysphoria:** Distress experienced by some individuals whose gender identity does not correspond with their assigned sex at birth. Manifests itself as clinically significant distress or impairment in social, occupational, or other important areas of functioning. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) includes gender dysphoria as a diagnosis. Gender dysphoria is not the same as gender nonconforming or being gay/lesbian.
- **Gender Expression:** The outward manner in which an individual expresses or displays their gender. This may include choices in clothing and hairstyle, or speech and mannerisms. Gender identity and gender expression may differ; for example a woman (transgender or non-transgender) may have an androgynous appearance, or a man (transgender or non-transgender) may have a feminine form of self-expression.

APPENDIX A: EXAMPLE CLINIC NONDISCRIMINATION POLICY CONTINUED

- **Gender Fluid:** Describes a person whose gender identity is not fixed. A person who is gender fluid may always feel like a mix of the two traditional genders, but may feel more one gender some days, and another gender other days
- **Gender Identity:** A person's internal sense of self and how they fit into the world, from the perspective of gender. An internal sense of being a man/male, woman/female, both, neither, or another gender.
- **Gender Identity Data:** Includes chosen name, chosen pronouns, current gender identity, and sex listed on original birth certificate. Failure to collect and use gender identity data has several important repercussions, including difficulties in tracking the organ inventories and preventive health needs of transgender people, invisibility of gender and sexual minority populations to policy makers and researchers, and reduced patient satisfaction due to a failure to use chosen names and pronouns.
- **Gender Nonconforming:** A person whose gender identity differs from that which was assigned at birth, but may be more complex, fluid, multifaceted, or otherwise less clearly defined than a transgender person. Genderqueer is another term used by some with this range of identities.
- **Intersex:** Group of rare conditions where the reproductive organs and genitals do not develop as expected. Some prefer to use the term disorders (or differences) of sex development. Intersex is also used as an identity term by some community members and advocacy groups. (Avoid outdated term of Hermaphrodite)
- **LGBTQ2:** (Lesbian, Gay, Bisexual, Transgender, Queer (or Questioning), Two-Spirit Community) "Two-spirited" refers to a person who has both a masculine and a feminine spirit, and is used by some First Nations people to describe their sexual, gender and/or spiritual identity.
- **Nonbinary:** Transgender or gender nonconforming person who identifies as neither male nor female.
- **Sex:** Historically has referred to the sex assigned at birth, based on assessment of external genitalia, as well as chromosomes and gonads. In everyday language is often used interchangeably with gender, however there are differences, which become important in the context of transgender people.
- **Sexual Orientation:** Describes sexual attraction only, and is not directly related to gender identity. The sexual orientation of transgender people should be defined by the individual. It is often described based on the lived gender; a transgender woman attracted to other women would be a lesbian, and a transgender man attracted to other men would be a gay man.
- **SO/GI:** Refers to sexual orientation and gender identity data used to track and improve LGBT health outcomes.
- **They/Them/Their:** Gender neutral pronouns used by some who have a nonbinary or nonconforming gender identity.
- **Transgender:** A person whose gender identity differs from the sex that was assigned at birth. May be abbreviated to trans. A transgender man is someone with a male gender identity and a female birth assigned sex; a transgender woman is someone with a female gender identity and a male birth assigned sex. (Avoid the term tranny as this is outdated and considered offensive)

APPENDIX A: EXAMPLE CLINIC NONDISCRIMINATION POLICY CONTINUED

- **Trans-masculine / trans-feminine:** Terms to describe gender nonconforming or nonbinary persons, based on the directionality of their gender identity. A trans-masculine person has a masculine spectrum gender identity, with the sex of female listed on their original birth certificate. A trans-feminine person has a feminine spectrum gender identity, with the sex of male listed on their original birth certificate. In portions of these Guidelines, in the interest of brevity and clarity, transgender men/women are inclusive of gender non-conforming or nonbinary persons on the respective spectræ.
- **Transsexual:** A more clinical term which had historically been used to describe those transgender people who sought medical intervention (hormones, surgery) for gender affirmation. Term is less commonly used in present day; however some individuals and communities maintain a strong and affirmative connection to this term.
- **Two-Spirit:** A contemporary term that connects today's experiences of LGBT Native American and American Indian people with the traditions from their culture (avoid outdated term of Berdache).
- **Ze/Hir/Hirs:** Gender neutral pronouns used by some who have a nonbinary or nonconforming gender identity. Pronounced zee/hear/hears

Procedures:

For the purposes of clarity and simplicity, the term transgender will be used throughout these guidelines to refer to transgender, gender nonconforming, and genderqueer people as a set, unless otherwise indicated. Non-transgender people will be referred to as such.

1. Oklahoma City Indian Clinic (OKCIC) has established a Diversity Council who is responsible for addressing LGBTQ/Two-Spirit health and healthcare inequities throughout the Clinic. The Council has developed a strategic plan to increase data collection, ensure highest quality of care, and collaborate with community groups to better serve gender diverse patients.
2. A transgender care team has been established in the Endocrinology Clinic. Patients will still maintain their PCP care team for all other medical services. The Prevention Specialist in the Public Health Department will serve as the Case Manager to navigate transgender services within and outside the Clinic as warranted.
3. OKCIC staff members should be aware of basic terminology used by the LGBTQ2 community. In addition to the terminology described in these guidelines (which are based on North American English language use), other local or individual terms may exist and also may change over time.
4. Each patient should be approached as an individual with no preconceptions. When addressing patients, avoid using gender specific terms like "sir" or "ma'am". Ask "How may I help you today?" as an alternative.
5. Patient privacy must be protected and discussions related to an individual's gender identity must be done privately. Never "out" someone without their permission. Once a patient's preferences are known, they should be referred to by their preferred (chosen) name and pronoun during the entire visit.

APPENDIX A: EXAMPLE CLINIC NONDISCRIMINATION POLICY CONTINUED

6. When conducting patient care, clinical staff should use a gender affirming approach. Gender affirmation is when an individual is affirmed in their gender identity through social interactions. This may also include using general terminology for body parts, or asking patients if they have a preferred term to be used.
7. Staff members are encouraged to foster an environment of accountability and not be afraid to politely correct a colleague if they use the wrong name and pronoun, or if they make insensitive comments. Creating an environment of accountability and respect requires everyone to work together.
8. Single-occupant gender neutral restrooms are available throughout the OKCIC campus for the comfort of gender diverse patients and visitors.
9. All patients are given an opportunity to communicate their Sexual Orientation / Gender Identity (SO/GI) preferences including preferred name, so that they may be addressed in the way they wish to be addressed. Preferred names are identified in RPMS/EHR with an asterisk to the right of the name. Preferred pronouns will be communicated to clinical staff through the use of Patient Flags in RPMS/EHR. Preferred pronouns include she/her/hers for transgender women and he/him/his for transgender men. Some individuals may identify outside of the gender binary and not identify strictly as male or female. They may prefer gender neutral pronouns that can include they/them/their or other, new pronouns such as ze/hir/hirs (pronounced zee/hear/hears). SO/GI data will be captured and recorded as follows:
 - a. SO/GI data is entered into RPMS/EHR in the Patient Registration package.
 - b. Data collected at the provider-level should be communicated to the Patient Registration Department for data entry.
 - c. Registration staff will notify the Health Information Management (HIM) Director to set up a patient identity flag in the electronic health record that includes the patient's preferred name and pronoun.
 - d. Clinical staff members are presented with the flag (dialog box) when accessing a patient's electronic health record to initiate care. The preferred name and pronoun should be used consistently in all conversations with or about the patient. The SO/GI information will also assist the care team in providing services and treatments that fit the patient's individual health care needs.
10. Gathering gender identity information by clinical staff is typically done using the two-step method:
 - a. Gender Identity
 - Male
 - Female
 - Transgender Male
 - Transgender Female
 - Other _____
(Identifies as Two-Spirit)
(Not exclusively male or female)
(Do not identify as male, female, or transgender)
 - b. Sex assigned at birth (on birth certificate)

APPENDIX A: EXAMPLE CLINIC NONDISCRIMINATION POLICY CONTINUED

11. The patient's sex assigned at birth will be identified in the "Birth Sex" field in RPMS/EHR to ensure appropriate preventative health reminders are addressed. For example: an affirmed woman will still have a prostate gland and an affirmed man may still have his uterus and ovaries.
12. The "legal sex" gender marker may be identified in RPMS/EHR in the SO/GI section and must include the legal document source and effective date.
13. Health Level Seven (HL7) refers to a set of international standards for transfer of clinical and administrative data between software applications used by various healthcare providers. HL7 codes for "administrative gender" are separate and distinct from current gender identity and assigned sex at birth. Administrative gender data should only be used as necessary, such as for insurance billing purposes and should not be used for identifying, housing, or communicating with patients. As rules regarding insurance coverage for transgender individuals change, this use is expected to become obsolete.
14. Section 1557 of the Affordable Care Act (ACA) prohibits discrimination in health coverage and care based on sex, including discrimination based on gender identity or sexual orientation. That means that most insurers, including Medicare, Medicaid, and insurance companies that offer state and federal Marketplace plans, cannot deny or limit coverage simply because the treatment someone is receiving is related to their gender identity. For example, an insurance company cannot automatically deny coverage for transition-related care. If the plan covers a treatment for other people, the carrier cannot refuse to cover the same treatment simply because it is being used by a transgender individual, or because it is being used to treat transgender dysphoria. This law applies to Marketplace insurance plans in Oklahoma. Patients that believe a health insurance plan is violating their rights should be referred to the Senior Benefits Coordinator for assistance.

APPENDIX B:

EXAMPLE TRIBAL ID DOCUMENTS

Confederated Tribes of Siletz Indians



FORM # ENROLL-008



Confederated Tribes of Siletz Indians Enrollment Department

201 SE Swan Ave
PO Box 549
Siletz, Oregon 97380-0549
Telephone: (541)444-8258 • Toll Free: (800) 922-1399 ext. 1258
E-Mail: angelar@ctsi.nsn.us

- Enrollment Staff Use -

Rec'd: _____
By: _____
Entered: _____
By: _____

Siletz Tribal Identification (ID) Request

Please print clearly in blue or black ink

INSTRUCTIONS: If you are not able to come into the Enrollment office to have your Tribal ID issued in person, you can order it by submitting this form. If there is no photo/signature on file or your photo on file is over twelve (12) months old, complete this form to order a Siletz Tribal ID to be issued and it will be sent to you via Certified mail.

Siletz Tribal Member: _____ Roll#: _____

- ☐ 1. **Updated Address:** Submit an "Address & Contact Information Update" form
- ☐ 2. **Height:** _____ feet _____ inches **Weight:** _____ pounds
- ☐ 3. **Digital Photo Specifications:** Email to "angelar@ctsi.nsn.us"
- a. In color, no filters and clearly focused
 - b. Plain white or off-white background
 - c. Taken within the last six-months to reflect your current appearance
 - d. Taken in full-face view directly facing the camera, no shadows on your face
 - e. Both eyes open, neutral/smiling facial expression, no hats
 - f. No sunglasses (even if tinted prescription glasses)
 - g. Glare on clear glasses is not acceptable. Glare can be avoided by slight downward tilt of glasses, turning off the flash or removing the glasses.
- ☐ 4. **Photo Verification:** Submit a color copy of your State issued ID to confirm your identity
- ☐ 5. **Signature:** Sign within the box in front of a notary as this is what will be used on your ID card

Date

Relationship to Tribal Member: ☐ Self ☐ Parent ☐ Guardian of Minor* ☐ Guardian of Adult*
*Attach court or other legal documentation to show Guardianship/Power of Attorney

REQUIRED NOTARIZATION FOR SIGNATURE VERIFICATION

STATE OF _____

COUNTY OF _____

This instrument was acknowledged before me on _____ (date) by
_____ (name of person).

Notary Public:

Print Name: _____

My Commission Expires: _____

ADOPTED PER RESOLUTION 2015-266, 9/18/2015

The Confederated Tribes of Siletz Indians does not include a gender marker on their Tribal ID Card.

Their Tribal Identification Request Form therefore does not need to ask about gender.

APPENDIX B: EXAMPLE TRIBAL ID DOCUMENTS CONTINUED

The Confederated Tribes of Siletz Indians include "Nonbinary" as a gender option for individuals seeking to change their name on the tribal roll.

FORM # ENROLL-004

SILETZ TRIBAL OFFICE USE ONLY	
RECEIVED DATE: _____	RECEIVED BY: _____
COMPLETE DATE: _____	POST #: _____



Confederated Tribes of Siletz Indians
Enrollment Department
201 SE Swan Ave
PO Box 549
Siletz, Oregon 97380-0549
Telephone: (541)444-8258 • Toll Free: (800) 922-1399 ext. 1258

Request for Name Change

INSTRUCTIONS: To change your name on the Siletz Tribal Roll you must submit legal documentation (Marriage Certificate, Court Order, Divorce Decree, etc.) and a copy of your social security card showing your legal updated name. **Failure to provide these documents will result in no action being taken.**

NOTE: For IRS tax purposes (*per capita*, etc.) it is important your name on the Tribal Roll and your Social Security Card match exactly.

Siletz Tribal Roll #: _____

Change From (Current Name on Tribal Roll):

FIRST NAME	MIDDLE	LAST
_____	_____	_____

Change To: (As listed on Social Security Card)

FIRST NAME	MIDDLE	LAST
_____	_____	_____

Required documentation submitted:

- ☐ ORIGINAL * legal documentation showing my name change
- ☐ A clear COLOR COPY of my social security card showing the name change

*Originals will be returned via Certified mail after staff has made a copy for your request

I certify the above information is correct and current.

X

Signature of Tribal Member/Guardian

Date

Phone Number: _____

Email Address: _____

APPENDIX C:

EXAMPLE GUIDELINES FOR GENDER-AFFIRMING CARE

Click each link to learn more:

UCSF Transgender Care Navigation Program

**Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons:
An Endocrine Society Clinical Practice Guideline**

**Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse
Children and Adolescents**

World Professional Association for Transgender Health

(Note: Some of the language used by WPATH could be considered outdated.)

APPENDIX D:

EXAMPLE ORGAN INVENTORY IN EHR

Oklahoma City Indian Clinic

Template: LGBTQ Gender Identity and Organ Inventory

Oklahoma City Indian Clinic

Patient Name: DEMO, PATIENT Chart: 09-99-92
DOB: AUG 15, 1989 Age: 29 Sex: MALE

Gender Assigned at Birth:
☒ Female ☐ Male ☐ Unknown

Current Gender Identity:
☐ Male/Man
☐ Female/Woman
☐ TransMale/TransMan
☐ TransFemale/TransWoman
☐ Other:

Organ Inventory:
☐ Penis
☐ Testes
☐ Prostate
☐ Breasts
☐ Vagina
☐ Cervix
☐ Uterus
☐ Ovaries

* Indicates a Required Field

Preview

OK

Cancel

APPENDIX E: SAMPLE QUESTIONS FOR INTAKE FORMS

Native Advocacy Workgroup for Trans Health

Sexual Orientation & Gender Identity Measures:

What is your sexual orientation? [Check all that apply.]

- | | |
|--|---|
| ☐ Two Spirit | ☐ Asexual |
| ☐ Straight or heterosexual | ☐ Questioning |
| ☐ Lesbian, gay, or homosexual | ☐ Queer |
| ☐ Bisexual | ☐ Not listed: _____ |
| ☐ Pansexual | ☐ Choose not to disclose |

What is your gender identity? [Check all that apply.]

- | | |
|--------------------------------------|---|
| ☐ Two Spirit | ☐ Nonbinary |
| ☐ Man | ☐ Agender |
| ☐ Woman | ☐ Genderqueer |
| ☐ Trans man | ☐ Genderfluid |
| ☐ Trans woman | ☐ Not listed: _____ |
| ☐ Transgender | ☐ Choose not to disclose |

Please indicate your sex assigned at birth:

- ☐ Male ☐ or Are you intersex?
- ☐ Female ☐ Yes
- ☐ No

Additional Clinical Measures:

Name: _____

 Last First Middle

Legal Name (if different from above): _____

Please indicate your pronouns: _____

APPENDIX E: SAMPLE QUESTIONS FOR INTAKE FORMS *CONTINUED*

Additional Clinical Measures *continued*:

I have:

- | | |
|-----------------------------------|---------------------------------------|
| ☐ Ovaries | ☐ Chest tissue |
| ☐ Penis | ☐ Uterus |
| ☐ Prostate | ☐ Cervix |
| ☐ Vagina | ☐ Testes |

If relevant for care:

In the past three months, with how many partners have you been sexually active? _____

In the past three months, what kinds of sex did you have? [Check all that apply.]

- | | |
|--|--|
| ☐ Receptive anal sex | ☐ Receptive oral sex |
| ☐ Insertive anal sex | ☐ Insertive oral sex |
| ☐ Receptive vaginal sex | ☐ Stimulation using toys (dildo, butt plug, etc.) |
| ☐ Insertive vaginal sex | ☐ Stimulation using hands (fisting, hand job, etc.) |

APPENDIX F:

SAMPLE CONSENT FORMS FOR HORMONE THERAPY

Consent Form – Testosterone

This form refers to the use of testosterone by persons who wish to become more masculinized as part of a gender transitioning process.

Your initials of the various statements on this form indicate that the risks as well as the changes which may occur as a result of the use of testosterone have been explained to you and that you understand them. If you have questions or concerns about this information, you are encouraged to take the time you need to ask for clarification, read, research, talk with staff, and think about the potential effects of this treatment before signing this document.

IF YOU DO NOT UNDERSTAND THIS INFORMATION, PLEASE STOP AND ASK FOR CLARIFICATION.

Please have the Legally Authorized Representative initial each section below to indicate that you understand and agree with the statements.

Masculinizing Effects

1. I/my child have been informed that the masculinizing effects of testosterone therapy may take several months to become noticeable and more than five (5) years to be complete.

I/my child understand that the following changes will be permanent:

- Hair loss at the temples and crown of the head, possibly male-pattern baldness
- Facial hair growth (beard, moustache)
- Deepening of my voice (lower voice pitch)
- Increased body hair growth (arms, legs, chest, back, buttocks, abdomen, etc.)
- Genital changes may be permanent (clitoral enlargement)

I/my child understand that the following changes are usually not permanent:

- Redistribution of fat to a male pattern (i.e., abdominal fat may increase while fat in the breasts, buttocks, and thighs may decrease)
- Increased muscle development
- Increased sex drive and energy levels. Possibly increased feelings of aggression or anger
- Acne, which may become severe and cause scarring without treatment
- Cessation of menstrual cycles (periods), suspended ovulation (maturing of ova/eggs), and genital changes (usually thinning of vaginal tissue leading to increased potential for easy damage, dryness, or yeast infections) may not be permanent

APPENDIX F: SAMPLE CONSENT FORMS FOR HORMONE THERAPY CONTINUED

I/my child understand that there are some aspects of the body that will not be changed by testosterone:

- Breasts may appear slightly smaller due to fat loss, but will not substantially shrink
 - Although voice pitch will likely drop, other aspects of speech will not become more masculine.
2. I/my child have been informed that it is not known exactly what the effects of testosterone are on fertility and that if the testosterone is stopped; it may or may not be possible to get pregnant in the future. I/my child have been advised to undergo gamete (egg) banking if this is a concern.
 3. I/my child have been informed that brain structures are affected by testosterone and estrogen. The long-term effects of changing levels of one's natal estrogen through the use of testosterone therapy have not been scientifically studied and are impossible to predict. These effects may be beneficial, damaging, or both.
 4. I/my child have been informed that everyone's body is different and that there is no way to predict what the response to hormones will be. I/my child have also been informed that the right dosage for me/my child may not be the same as for someone else and that in order to continue to receive hormone therapy at this clinic, the prescribed regimen of testosterone treatment must be followed.
 5. I/my child have been informed that physical examination and lab tests will be needed periodically to monitor the effects of testosterone on the body and that this is required to continue therapy at this health center.

Risks of Testosterone and Prevention of Medical Complications

6. I/my child have been informed that the medical effects and safety of testosterone are not fully understood, and that there may be long-term risks that are not yet known.
7. I/my child have spoken to an affirming behavior health clinician (such as a psychiatrist, psychologist, or counselor) regarding the decision to pursue masculinizing therapy. Aside from starting masculinizing therapy, it is strongly recommended to engage in on-going psychotherapy because it may offer support as I/my child continue to develop gender identity, adjust to body changes, and negotiate relationships with other important people in my/my child's life.
8. I/my child have been informed and strongly advised not to take more testosterone than prescribed, as this increases health risks. I/my child have been informed that taking more will not make masculinization happen more quickly or increase the degree of change. Extra testosterone can be converted to estrogen, which may slow or stop masculinization.
9. I/my child have been informed that testosterone can cause changes that increase the risk of heart disease:
 - Decreasing good cholesterol (HDL), increasing bad cholesterol (LDL)
 - Increasing blood pressure
 - Increasing fat deposition around my internal organs

Risks of Testosterone and Prevention of Medical Complications (continued)

10. I/my child have been informed that the risks of heart disease are greater if people in the family have had heart disease, if I/my child am overweight, or smoke cigarettes.
11. I/my child have been informed that testosterone can increase the risk for diabetes by decreasing the body's response to insulin, causing weight gain, and increasing fat deposition around internal organs. I/my child have been advised that glucose levels will be monitored periodically while taking testosterone.
12. I/my child have been informed that testosterone may lead to liver inflammation and damage and that I/my child will be monitored for liver problems before starting testosterone therapy and periodically during therapy.
13. I/my child have been informed that testosterone can increase red blood cells and hemoglobin, and while the increase is usually only to a normal range for males (which does not pose health risks); a high increase can cause potentially life-threatening problems such as stroke and heart attack. I/my child have been advised that my/my child's blood will be monitored periodically while on testosterone.
14. I/my child have been informed that testosterone can be converted to estrogen by various tissues in the body, and that it is not known whether this increases the risk of ovarian cancer, breast cancer, or uterine cancer. I/my child have been advised that pelvic exams and regular cervical cancer screenings are strongly recommended unless there has been a removal of the ovaries, uterus, and cervix. Annual breast exams, monthly self-exams and annual mammograms after the age of 40 are highly recommended, even after chest reconstruction.
15. I/my child have been informed that testosterone can lead to the cervix and the walls of the vagina becoming more fragile, and this can lead to tears or abrasions that increase the risk of sexually transmitted infections (including HIV) from having vaginal sex. A frank discussion with the doctor about sexual practices can help determine how best to prevent and monitor for sexually transmitted diseases.
16. I/my child have been informed that the effects of testosterone therapy by itself will not provide protection from sexually transmitted diseases or HIV. Use of barriers and safer sexual practices are recommended to reduce chances of infections.
17. I/my child have been informed that testosterone therapy should not be relied upon to prevent pregnancy. Even with the cessation of periods, use of a barrier method of birth control is advised during sex where semen could enter the vagina or uterus.
18. I/my child have been informed that testosterone therapy can cause headaches or migraines. If frequent headaches or migraines occur, or if the pain is unusually severe, it is recommended to talk with the health care provider. I/my child have been informed that the masculinizing effects of testosterone therapy may take several months to become noticeable and more than five (5) years to be complete.
19. I/my child have been informed that testosterone therapy may cause changes in emotions and moods, including increased irritability, frustration and anger. I/my child have been advised that the providers can assist in finding support services and other resources to explore and cope with these changes.

Risks of Testosterone and Prevention of Medical Complications (continued)

20. I/my child agree that if I/my child have any adverse reactions or side effects to testosterone I/my child will inform the provider.
21. I/my child agree to tell the provider about any non-clinic hormones, dietary supplements, herbs, recreational drugs, or medications I/my child might be taking. Sharing this information will help the provider to prevent potentially harmful interactions. I/my child have been informed that staff will continue to provide medical care, regardless of what information is shared with them.
22. I/my child agree to take testosterone as prescribed and to inform the provider of any problems or dissatisfaction I/my child may have with the treatment.
23. I/my child agree that physical examinations, blood tests and check-ups are needed on a regular basis to monitor changes and check for negative side effects of testosterone.
24. I/my child have been informed that there are medical conditions that could make taking testosterone dangerous. If the provider suspects I/my child may have any condition that could be dangerous, I/my child agree to be evaluated for it before the decision to start or continue testosterone therapy is made.
25. I/my child have been informed that I/my child can choose to stop taking testosterone at any time and that it is advised to do this with the help of the health care provider. I/my child also understand that the provider can discontinue treatment for clinical reasons. I/my child agree to follow a prescribed reduction plan if either of these situations occurs to reduce negative, potentially harmful side effects that may occur if I/my child suddenly stop taking testosterone.

APPENDIX F: SAMPLE CONSENT FORMS FOR HORMONE THERAPY CONTINUED

All of the information above has been explained to my satisfaction AND (check only one):

- ☐ I/my child choose to begin testosterone therapy
- ☐ I/my child do not wish to begin testosterone therapy at this time.

SIGNATURES

By signing below, I acknowledge that I/my child have been provided the opportunity to have any questions answered to my satisfaction concerning the testosterone therapy. I believe I know enough to give informed consent for me/my child to take, refuse or postpone using the proposed medications. I understand and have had the opportunity to ask questions about the risks, benefits and alternatives, and consent to the treatment as discussed with my/my child’s physician. I have no further questions. I understand that no guarantees have been made to me about the results of the process.

Signature of Patient	Printed Name of Patient	Date	Time
Signature of Legally Authorized Representative		Date	Time
Signature of Legally Authorized Representative		Relationship to Patient	
Witness’ Signature		Date	Time
Practitioner’s Signature	Printed Name of Patient	Date	Time

(I have explained to the above patient/legally authorized representative the nature of this process. In addition to the advising of the medically acceptable benefits and possible alternative modes of treatment, I have explained in lay terms the risks, benefits and alternatives which are or may be associated with this treatment.)

Interpreter Signature/Telephonic ID Number	Interpreter’s Printed Name	Date	Time
--	----------------------------	------	------

Consent Form – Feminizing Hormones

This form refers to the use of estrogen and/or androgen antagonists (also called “anti-androgens” or “androgen blockers”) by persons who wish to become more feminized as part of a gender transitioning process.

Your initials of the various statements on this form indicate that the risks as well as the changes which may occur as a result of the use of estrogen and/or androgen antagonists have been explained and that you understand them. If you have any questions or concerns about this information, you are encouraged to take the time you need to ask for clarification, read, research, talk with staff and think about the potential effects of this treatment before signing.

IF YOU DO NOT UNDERSTAND THIS INFORMATION, PLEASE STOP AND ASK FOR CLARIFICATION.

Please have the Legally Authorized Representative initial each section below to indicate that you understand and agree with the statements.

Feminizing Effects

1. I/my child have been informed that the feminizing effects of estrogen and androgen antagonists can take several months to become noticeable, several years to be complete, and that the rate and degree of change cannot be predicted.

I/my child have been informed that the following changes are permanent (they will not reverse, even if I/my child stop taking feminizing medications):

- Breasts may take several years to develop fully. There are natural variations in the size of breasts, and one person’s breast development does not correlate with that of another person’s. Even if estrogen therapy is discontinued, the breast tissue that has developed will remain. As soon as breasts start growing, it is recommended to start doing monthly self-exams and to have annual breast exams by a health care provider. It is not known if taking estrogen increases the risk of breast cancer. Also, there may be milky nipple discharge (galactorrhea). This can be caused by taking estrogen or by an underlying medical condition. It is advised to check with a doctor to determine the cause if you experience galactorrhea.

I/my child have been informed that the following changes are not permanent (they will reverse if I/my child stop taking feminizing medications):

- Skin may become softer
- Muscle mass decreases and there may be a decrease in upper body strength
- Facial and body hair growth may become less noticeable and grow more slowly, but it will not likely stop completely
- Male pattern balding may slow down, but it will probably not stop
- Redistribution of body fat to a more female pattern (i.e. abdominal fat may decrease while fat on the buttocks/hips/thighs may increase)

APPENDIX F: SAMPLE CONSENT FORMS FOR HORMONE THERAPY CONTINUED

I/my child have been informed that there are some aspects of the body that will not be changed by feminizing medications:

- Beard/moustache hair may grow more slowly but will not go away
 - Voice pitch will not rise and speech patterns will not become more feminine
 - The laryngeal prominence (Adam's apple) will not shrink
2. I/my child have been informed that it is not known exactly what the effects of estrogen therapy are on fertility. Estrogen decreases hormones that support the size and function of testicles, and this may affect overall sexual functioning and fertility. The changes that may occur include:
- Up to 40% shrinkage in size of the testicles
 - Decrease in testosterone production from the testicles
 - Sperm will still be present in the testicles, but may stop maturing which may cause infertility
 - If estrogen therapy is stopped, the ability to make healthy, mature sperm may or may not ever come back
 - The amount and quality of erections and ejaculation may decrease or stop entirely
 - Erections may no longer be firm enough for penetrative intercourse
 - There may be a decrease or loss of morning and spontaneous erections
 - Sex drive or libido may decrease

Risks Related to Estrogen

3. I/my child have been informed that the medical effects and safety of feminizing medications are not fully understood, and that there may be long-term risks that are not yet known.
4. I/my child have been informed that it is strongly advised not to take more estrogen prescribed, as this increases health risks.
5. I/my child have been informed that brain structures are affected by testosterone and estrogen. The long-term effects of changing the levels of one's natal testosterone through the use of estrogen therapy have not been scientifically studied and are impossible to predict. These effects may be beneficial, damaging, or both.
6. I/my child have been informed that estrogen can damage the liver, possibly leading to liver disease and that there is a slight risk of long-term estrogen use causing liver cancer. I/my child agree that while on estrogen therapy I/my child will be monitored for liver problems before and periodically during therapy.
7. I/my child have been informed that estrogen increases the risk of blood clots (thrombosis), which can result in:
- Deep vein thrombosis
 - Pulmonary embolism (blood clot to the lungs), which can cause permanent lung damage or death
 - Stroke (blood clot to the brain), which can cause permanent brain damage or death
 - Heart attack (blood clot to the heart), which may cause death
 - Chronic leg vein problems

Risks Related to Estrogen (continued)

8. I/my child have been informed that the risk of blood clots while on estrogen therapy is much higher if I/my child smoke tobacco, especially if over the age of 35. The danger is so high that I/my child should stop smoking completely if estrogen therapy is started. The medical provider can offer options to assist with the process of stopping smoking if so desired or needed.
9. I/my child have been informed that estrogen may increase fat deposition around internal organs, which is associated with increased risk for diabetes and heart disease.
10. I/my child have been informed that estrogen may cause increased blood pressure. If I/my child have existing high blood pressure or develop high blood pressure, the doctor will work with me/my child to control it with diet and exercise and/or medications.
11. I/my child have been informed that estrogen may raise triglycerides.
12. I/my child have been informed that estrogen may increase migraine headaches and that this may be a reason to choose to stop taking estrogen or may be a reason for estrogen to be discontinued by the provider.
13. I/my child have been informed that estrogen may cause nausea and vomiting, similar to morning sickness in a pregnant woman. If I/my child experience nausea and vomiting that is severe and/or prolonged, it should be discussed with the doctor.
14. I/my child have been informed that estrogen increases the risk of gallstones and that if I/my child have abdominal pain that is severe or prolonged, it is recommended to discuss this with the doctor.
15. I/my child have been informed that it is not known if taking estrogen increases the risk of non-cancerous tumors of the pituitary gland (prolactinoma). While this is not typically life-threatening, it can damage vision and cause headaches and will be monitored for at least three years after starting estrogen.
16. I/my child have been informed that it can take six months to notice a decrease in hair growth while on spironolactone treatment.
17. I/my child have been informed that spironolactone affects the balance of water and salts in the kidneys, which may:
 - Increase the amount of urine produced, making it necessary to urinate frequently
 - Increase thirst
 - Reduce blood pressure
 - Rarely, spironolactone may cause high levels of potassium in the blood, which can cause changes to the heart rhythm and be life- threatening
18. I/my child have been informed that if feeling sick or unable to eat for any reason (e.g. diarrhea, vomiting, fasting for labs or surgery, etc.), I/my child should not take the spironolactone, as this may cause me/my child to become more easily dehydrated and develop high sodium levels, which can be dangerous. Skipping spironolactone for a few days will not substantially impact the effect it has on the body. Call the health care provider with any questions.
19. I/my child have been informed some androgen antagonists make it more difficult to evaluate the results of PSA (prostate- specific antigen), which may make it more difficult to monitor prostate problems. If I am over 50, I should have my prostate evaluated every year.

Prevention of Medical Complications

20. I/my child have spoken to an affirming behavior health clinician (such as a psychiatrist, psychologist, or counselor) regarding the decision to pursue feminizing therapy. Aside from starting feminizing therapy, it is strongly recommended to engage in on-going psychotherapy because it may offer support as I/my child continue to develop gender identity, adjust to body changes, and negotiate relationships with other important people in my/my child's life.
21. I/my child agree to take estrogen and other transition-related medications as prescribed and to inform the provider of any problems or dissatisfactions I/my child may have with the treatment. I/my child have been informed that the right dose or type of medication prescribed for me/my child may not be the same as for someone else.
22. I/my child have been informed that physical examinations and lab tests are required to check for negative side effects of feminizing medications and to continue good health care. This is required to continue hormone therapy through this health center.
23. I/my child agree to tell the provider about any non-clinic hormones, dietary supplements, herbs, recreational drugs, or medications I/my child might be taking. Sharing this information will help the provider to prevent potentially harmful interactions. The staff will continue to provide medical care, regardless of what information is shared with them. I/my child have been informed that the risk of blood clots while on estrogen therapy is much higher if I/my child smoke tobacco, especially if over the age of 35. The danger is so high that I/my child should stop smoking completely if estrogen therapy is started. The medical provider can offer options to assist with the process of stopping smoking if so desired or needed.
24. Due to breast development with estrogen therapy, I/my child understand that it will be necessary to do monthly self-breast examinations, have an annual medical exam, and, once 40 or older, I will need to have an annual mammogram.
25. I/my child have been informed that there is a slight chance that taking estrogen will cause overgrowth of the prostate. Prostate cancer screening is recommended for people 50 years of age and older as well as in younger people if otherwise medically indicated.
26. I/my child have been informed that there are medical conditions that could make it dangerous to take estrogen or androgen antagonists. If the provider suspects I/my child may have any condition that could be dangerous, I/my child agree to be evaluated for it before the decision to start or continue hormones is made.
27. I/my child have been informed that I/my child can choose to stop taking feminizing medication at any time, and that it is advised to do this with the help of the doctor to make sure there are no negative reactions to stopping. The doctor may suggest to reduce or stop taking feminizing medication, or switch to another type of feminizing medication, if there are side effects or health risks that can't be controlled.

APPENDIX F: SAMPLE CONSENT FORMS FOR HORMONE THERAPY CONTINUED

All of the information above has been explained to my satisfaction AND:

- ☐ I/my child choose to begin taking estrogen.
- ☐ I/my child choose to begin taking androgen antagonists (e.g. spironolactone).
- ☐ I/my child do not wish to begin taking feminizing medication at this time.

SIGNATURES

By signing below, I acknowledge that I/my child have been provided the opportunity to have any questions answered to my satisfaction concerning the use of feminizing medications. I believe I know enough to give informed consent for me/my child to take, refuse or postpone using the proposed medications. I/my child understand and have had the opportunity to ask questions about the risks, benefits and alternatives, and consent to the treatment as discussed with my/my child’s physician. I have no further questions. I understand that no guarantees have been made to me about the results of the process.

Signature of Patient	Printed Name of Patient	Date	Time
Signature of Legally Authorized Representative		Date	Time
Signature of Legally Authorized Representative		Relationship to Patient	
Witness’ Signature		Date	Time
Practitioner’s Signature	Printed Name of Patient	Date	Time

(I have explained to the above patient/legally authorized representative the nature of this process. In addition to the advising of the medically acceptable benefits and possible alternative modes of treatment, I have explained in lay terms the risks, benefits and alternatives which are or may be associated with this treatment.)

Interpreter Signature/Telephonic ID Number	Interpreter’s Printed Name	Date	Time
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Consent Form – Puberty Blockers

Before considering a medication for your child to put puberty “on hold”, there are several things you need to know. There are possible advantages, disadvantages and risks with pubertal blockers. We have listed them here for you. It’s important that you understand all of this information before your child begins the medication.

Please read the following carefully and ask us any questions you may have. We want you to be very comfortable and sure of what pubertal blockers offer your child.

After your questions or concerns are addressed, if you have decided to proceed with the pubertal blocker medication for your child, both you and your child will need to sign this consent form.

What are the possible advantages of putting my child’s pubertal development “on hold”?

For gender-questioning, gender-fluid, and transgender children, there are possible advantages to delaying or putting on hold changes brought on by puberty. First, blocking pubertal development can prevent potential distress that can result from body changes brought on by puberty. Second, the pause of pubertal development in gender-questioning children allows these children time to further explore and understand more about their gender identities and their bodies without distress associated with puberty changes. And, third, the pause of pubertal development may be especially beneficial to transgender girls (male to female) because transgender adult women who have undergone male puberty during adolescence are often unable to ‘pass’ as female because of certain irreversible body changes caused by male puberty (e.g., height, growth of Adam’s apple, lower pitch voice, widened stature, etc.). Being unable to ‘pass’ as female in adulthood may increase their safety risk and pose challenges to their integrating into society.

How can the physical changes of puberty be put “on hold”?

The main way that the physical changes of puberty can be put on hold is by blocking the signal from the brain to the organs that make the hormones of puberty. These hormones are estrogen and testosterone. Estrogen is made by the ovaries. Testosterone is made by the testicles.

What are the different medications that can put “on hold” the physical changes of puberty?

These medications are called Pubertal Blockers. Lupron™ is given monthly. Histrelin acetate (Supprelin®, Vantas®) is a subcutaneous implant that delivers medication for one year. These medications are effective for both males and females. They can be started just after the early physical changes of puberty.

For young adolescents who identify as female (but are born with male bodies), there are alternative medicines that can block the effect of testosterone. The most common medication of this type is called spironolactone. There is a separate consent form for this medication. Spironolactone is not as effective at blocking puberty in these youth, but it is much cheaper in price than Lupron™ or histrelin acetate.

CONTINUED

For young adolescents who identify as male (but are born with female bodies), there are several reversible medications that can be used to block periods. These medications are not as effective at blocking many of the physical changes that puberty leads to in these youth, but are cheaper in price than Lupron TM or histrelin acetate.

Every medication has risks, benefits, and side effects that are important to understand before starting. It is also important to know how they work. Please have the Legally Authorized Representative initial each statement on this form to show that you understand the benefits, risks, and changes that may occur for your child by taking these medications.

Medications for Blocking Puberty

I have been informed that puberty blockers are used to help temporarily suspend or put “on hold” the physical changes of puberty for my child. If not suspended, some of the physical changes of puberty are permanent.

I have been informed it can take several months for the medication to be effective. I know that no one can predict how quickly or slowly my child’s body will respond to medication.

This medication is not specifically made for the purpose of blocking puberty in youth who may be gender-questioning, gender-fluid, or transgender and exploring their gender identity (they are not approved for this purpose by the Federal Drug Administration (FDA); however, pediatric endocrinologists (doctors who work with hormones and puberty), pediatricians, and behavioral health clinicians (for example, psychiatrists, psychologists, and counselors), may recommend these medications if it is determined that the physical changes of puberty need to be postponed. Puberty blockers (LupronTM) have been used to block puberty in children with a condition known as precocious puberty (when puberty starts too early) for many years.

I have been informed that the effects of the medication are not permanent. If my child stops getting the injections, in about six months my child’s body will restart the changes of puberty at the developmental stage they were at when they started the hormone blocker.

I have been informed that by taking these medications, my child’s body will not be making the hormones of puberty, testosterone or estrogen. At this time, I support my child in “putting on hold” the hormones and the changes that they cause in puberty.

I have been informed that by providing these medications to my child I am avoiding the potential distress that physical changes brought on by puberty may have on my child, allowing exploration of gender identity over time without the fear of irreversible physical changes occurring.

I have been informed that by providing these medications to my child I may be helping them avoid the need for surgeries and other treatments (e.g., mastectomies for transgender men, tracheal shaving or electrolysis for transgender women) that some may eventually seek to reverse the effects of an undesired puberty.

APPENDIX F: SAMPLE CONSENT FORMS FOR HORMONE THERAPY CONTINUED

CONTINUED

I have been informed that especially with transgender girls (male to female) this may also improve their safety and integration into society when they are adults. This is because transgender women who have undergone male puberty are often unable to 'pass' as female because of irreversible changes that male puberty causes.

I have been informed that if my child identifies as female (but is born with a male body), my child can take spironolactone instead of puberty blockers to block the effects of testosterone. If we are interested in this medication, we can review and sign a separate consent form.

I have been informed that if my child identifies as male (but born with a female body), my child can take a different medication instead of puberty blockers to prevent a monthly period from occurring (which may be very distressing to them). If we are interested in this medication, we can review and sign a separate consent form.

I have been informed that if I have any concerns about these issues I can meet with a pediatric endocrinologist to help us explore this and other options.

I have been informed that it is strongly recommended that my child and our family follow up with a behavioral health clinician (for example, a psychiatrist, psychologist, or counselor) who is experienced in gender issues while my child is taking puberty blockers at a frequency determined by that clinician and how my child is doing at the time.

I have been informed that I can ask my child's provider and therapist for help advocating for my child.

Risks of Puberty Blockers

I have been informed that the side effects and safety of these medications are not completely understood. There may be long-term risks that are not yet known.

I realize there may be a stalling of typical adolescent cognitive or brain development while on these medications. Puberty hormones (testosterone and estrogen) usually help with cognitive development and aspects of emotional development in the adolescent brain. The long-term effects of puberty blocking medications on brain development in this population have not been formally studied.

I have been informed that my child's growth should not stop while on puberty blockers, but the rate of growth may be slower compared to the rate typically observed during puberty. This can be beneficial for young adolescents who identify as female (but are born with a male body) to achieve a typical female height. In young adolescents who identify as male (but are born with a female body), delaying the onset of puberty may actually slightly increase height (one of the reasons that girls are usually shorter than boys is because puberty is typically started earlier in girls).

CONTINUED

I have been informed that blocking puberty will stop further development of genital tissue (scrotal and penile tissue in natal males and vaginal tissue in natal females), and this may impact my child's options for future gender confirmation surgery (if these are desired). Different types of surgeries may be associated with different risks and outcomes, and if I am interested in learning more about this, I am encouraged to contact a specialist in these types of surgeries.

I have been informed that common side effects of being on puberty blockers include headaches, fatigue, insomnia, muscle aches, mood changes and emotional lability (possible mood swings), weight gain and allergic reactions. Male-identified adolescents (born with a female body) may also experience breast tenderness and vaginal bleeding and female-identified adolescents (born with a male body) may experience gynecomastia (benign breast tissue growth).

I have been informed that additional side effects and risks of injectable forms of puberty blockers include pain and rash near the area of injection.

I have been informed that additional side effects and risks of implantable forms of puberty blockers include site reactions near the area of implantation (for example, bruising, discomfort, itching, pain, soreness, swelling and tingling), pain immediately following the procedure, scarring, itching, formation of sterile abscesses and other suture-related complications. Some people experience difficulty with removal of the implant. Rarely, the medication can cause seizures in children.

Prevention of Medical Complications

I have spoken to an affirming behavioral health clinician (such as a psychiatrist, psychologist, or counselor) regarding the decision to pursue pubertal blocking medication for my child. I am aware that aside from starting pubertal blocking medications, it is strongly recommended that my child engage in on-going psychotherapy because it may offer support as my child continues to explore and develop their gender identity, adjust to their bodies, and negotiate relationships with peers.

I support my child taking puberty blocking medication as prescribed by their health care provider. I agree to tell my health care provider if my child has any problems or side effects or is unhappy with the medication.

I have been informed that my child needs periodic check-ups to make sure that my child is responding appropriately to the medication.

I have been informed that using these medicines to block puberty is an off-label use. I know this means it is not approved by the Food and Drug Administration (FDA) for this specific use. I know that the medication that is recommended for my child is based on the judgment and experience of our health care providers and is supported by the Society of Pediatric Endocrinology.

I have been informed that my child can choose to stop taking these medications at any time. I know that if my child decides to do so, we should stop the medications with the help of my health care provider.

APPENDIX F: SAMPLE CONSENT FORMS FOR HORMONE THERAPY CONTINUED

My signature below confirms that:

- My child’s health care provider has talked with me about:
 - The advantages and risks of puberty blockers for my child.
 - The possible or likely consequences of using puberty blockers.
 - Any potential alternative treatments.
- I understand that my child’s health care provider has consulted with a pediatric endocrinologist about my child’s situation and that the endocrinologist concurs that the puberty blockers are appropriate for my child.
- I understand the risks that may be involved.
- I know that the information in this form includes the known effects and risks. I also know that there may be unknown long-term effects or risks.
- I have had enough opportunity to discuss treatment options with my child’s health care provider. All of my questions have been answered to my satisfaction.
- All of my questions have been answered to my satisfaction.
- I believe I know enough to give informed consent for my child to take, refuse, or postpone using puberty blocking medications
- My child is in agreement with this treatment and the signature of my child on the Child’s Puberty Blocker consent form specifically for my child attests to this agreement.
- My signature attests that I consent for my child to begin puberty blockers.

Based on all this information:

- ☐ I want my child to begin receiving puberty blocking medication
- ☐ I do not wish my child to begin taking puberty blocking medication at this time.

SIGNATURES

By signing below, I acknowledge that my child and I have been provided the opportunity to have any questions answered to my satisfaction concerning the use of puberty blockers. I believe I know enough to give informed consent for my child to take, refuse or postpone using the proposed medications. I understand and have had the opportunity to ask questions about the risks, benefits and alternatives, and consent to the treatment as discussed with me/my child’s physician. I have no further questions. I understand that no guarantees have been made to me about the results of the process.

Signature of Patient	Printed Name of Patient	Date	Time
Signature of Legally Authorized Representative		Date	Time
Signature of Legally Authorized Representative		Relationship to Patient	

CONTINUED ON NEXT PAGE...

SIGNATURES (CONTINUED)

By signing below, I acknowledge that my child and I have been provided the opportunity to have any questions answered to my satisfaction concerning the use of puberty blockers. I believe I know enough to give informed consent for my child to take, refuse or postpone using the proposed medications. I understand and have had the opportunity to ask questions about the risks, benefits and alternatives, and consent to the treatment as discussed with me/my child’s physician. I have no further questions. I understand that no guarantees have been made to me about the results of the process.

Witness’ Signature		Date	Time
Practitioner’s Signature	Printed Name of Patient	Date	Time

(I have explained to the above patient/legally authorized representative the nature of this process. In addition to the advising of the medically acceptable benefits and possible alternative modes of treatment, I have explained in lay terms the risks, benefits and alternatives which are or may be associated with this treatment.)

Interpreter Signature/Telephonic ID Number	Interpreter’s Printed Name	Date	Time

APPENDIX G:

SAMPLE PROTOCOL FOR HORMONE PRESCRIPTION

Note: This is a sample protocol only. Recommendations for these medications change frequently, more frequently than the updates to this document. Please verify hormone prescription protocols using the latest guidelines from **WPATH**, the **University of California, San Francisco**, or the **Endocrine Society**.

Follow up and lab schedule FTM

This is in addition to any other indicated lab monitoring based on other risks or disease states.

	All	Age > 30 or higher risk of CVD	Age > 40	Age > 50	Based on Risks/ Organs
Baseline	CBC, fasting CMP, BP	Lipids	chest/breast exam, Mammo if not s/p mastectomy		Pap[1] [2], STI screen[3], HCG if has uterus
2-3 mos p start or dose change	CBC, fasting glucose, ALT, Lipids, BP, Trough Total Testosterone			Approved By: Robin Parker Director of Policy Development	Board Approval Not Required
Q6 months	BP and exam				
Q12 months (stable dose)	CBC, fasting glucose, ALT, BP, Trough Total Testosterone	Lipids	chest/breast exam, Mammo if not s/p mastectomy	Consider osteoporosis screening if on testosterone > 5 yrs	Pap[1] [2], STI screen[3]

[1] Consider HPV testing if age > 30 or if significant emotional stress around pelvic exam so that q2-3 year screening may be done

[2] Let pathologist know if patient is on testosterone

[3] STI Screen = HIV, RPR, Hep A/B/C, GC/CT and consider Hep A/B vaccination

FTM Medication

Dose may be decreased after oophorectomy, but not in all cases

Medication	Start	Mid	Max
Testosterone cypionate	50 mg q 2 weeks	150 mg q 2 weeks	250 mg q 2 weeks
Testosterone enanthate	50 mg q 2 weeks	150 mg q 2 weeks	250 mg q 2 weeks
Androderm Patch	2.5 mg/patch qd	5 mg/patch qd	10 mg/patch qd
Androgel / Testim 1% gel	2.5 mg qd	5 mg qd	10 mg qd
Testosterone 5% cream (compounded)	0.25 g qd	1 g qd	2 g qd

[1] Adjust dose every 2-3 months to achieve desired changes and/or bring trough testosterone to lower half of male range

APPENDIX G: SAMPLE PROTOCOL FOR HORMONE PRESCRIPTION CONTINUED

Follow up and lab schedule FTM

This is in addition to any other indicated lab monitoring based on other risks or disease states.

	All	Spiro	Flutamide	Age > 30 or higher risk of CVD	Age > 40	Age > 50	Based on Risks/ Organs
Baseline	CBC, CMP BP		G6PD, consider MetHgb level if G6PD deficient or smoker	Lipids	Mammo if high-risk family history	Digital rectal exam, Consider PSA if high risk	STI screen ^[1]
2-3 mos p start or dose change	CBC, ALT, Lipids, BP, Prolactin	K+, Cr	LFT, consider MetHgb if risks	Lipids			
Q6 months	CBC, ALT, BP, Prolactin, Consider Total Testosterone if inadequate feminization	K+, Cr					
Q12 months (stable dose)	CBC, ALT, BP, Prolactin	K+, Cr		Lipids		Digital rectal exam; Mammo if > 5 yrs on hormones or high-risk family history	STI screen ^[1] , Pap smear ^{[2] [3]}

[1] STI Screen = HIV, RPR, Hep A/B/C, GC/CT and consider Hep A/B vaccination

[2] After vaginoplasty, do vaginal pap smear if history of genital warts and cervical pap smear if has neocervix

[3] Let pathologist know if patient is on estrogen

APPENDIX G: SAMPLE PROTOCOL FOR HORMONE PRESCRIPTION CONTINUED

FTM Medication

Daily dose listed for oral preps; dividing bid recommended for those at risk of liver toxicity

Hormones ^[1] ^[2]

Medication/Orchi status	Start	Mid	Max
Premarin / Pre	2.5 mg	5 mg	10 mg
Premarin / Post	1.25 mg		5 mg
Estradiol / Pre	1 mg	4 mg	6 mg
Estradiol / Post	1 mg		4 mg
Estradiol valerate / Pre	10 mg q 2 weeks	10 mg q 2 weeks	20 mg q 2 weeks
Estradiol valerate / Post	10 mg q 2 weeks		20 mg q 2 weeks
Estradiol patch / Pre	0.1 mg/d biw	0.2 mg/d biw	0.3 mg/d biw
Estradiol patch / Post	0.0375 mg/d biw		0.2 mg/d biw

Anti-Androgens^[3]

Medication/Orchi status	Start	Mid	Max
Spirolactone ^[4] ^[5]	50 mg qd	200 mg qd	500 mg qd
Flutamide ^[4]		125 mg bid	
Finasteride / Pre	2.5 mg qd	5 mg qd	5 mg qd
Finasteride / Post (androgenic alopecia)		1 - 1.25 mg qd	5 mg qd
Medroxyprogesterone (not routinely recommended) ^[4]	2.5 mg qd	5 mg qd	10 mg qd

Other

Medication/Orchi status	Start	Mid	Max
Aspirin if high risk CVD		81 mg qd	

[1] Adjust dose every 2-3 months to achieve desired changes; check testosterone levels if desired effects are not achieved at max doses

[2] Discontinue hormones 2-4 weeks prior to any major surgery to reduce the risk of thromboembolic events

[3] Spirolactone should be first-line anti-androgen

[4] Generally only used pre-orchietomy

[5] Can be divided bid