**FTM TOP SURGERY MEDICAL CLEARANCE LETTER SAMPLE**

Date

RE: DOB:

To Whom It May Concern:

Patient name is a patient in my care at Facility/office name. He originally established care with us on Date. Patient name has a transmasculine gender identity which is well established and stable. He notes he first knew his gender identity differed from his birth assigned sex at age. He has been consistently and successfully living in the gender role congruent with his identity since at least date, and (if taking hormones) he has been on consistent hormone therapy on date . By my independent evaluation, I have diagnosed him with Gender Dysphoria (ICD-10 F64.1/F64.9). He reports symptoms of anxiety, which he feels are exacerbated by his Dysphoria. He relates much of his Gender Dysphoria to his chest size. He binds his chest tightly to feel more comfortable in his body, which causes pain. Patient name has expressed a persistent desire for bilateral mastectomy with male chest reconstruction. He has sufficient social support to move through the surgical process. He has stable housing in City and has well developed plans for post-op recovery. I believe Patient name would benefit greatly both medically and psychologically from bilateral mastectomy with male chest reconstruction. This procedure has been defined as medically necessary by the World Professional Association for Transgender Health.

Additionally, Patient name is medically stable for surgery. His medical history is unremarkable (or any medical conditions are reasonably well controlled), making him an excellent candidate for surgery. BMI is \_\_\_\_ (required <37 for surgery). He does not smoke cigarettes or drink excessive alcohol, and is not at risk of or an active user of illicit drugs or drugs of abuse. He has no distracting or major psychiatric illnesses (or I verify that [psychotic disorders, bipolar disorder, major depressive disorder, borderline identity disorder, dissociative identity disorder, or substance abuse disorder] is/are well controlled.

Patient name has met the WPATH SOCv7 criteria for surgery. I feel he has capacity to provide informed consent for male chest reconstruction, and that he is ready, appropriate and medically clear for this procedure. I hereby recommend and refer Patient name for this surgery. Please feel free to contact me with any questions or concerns.

Sincerely,

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lic:

NPI:

DEA: