**MEDICAL CLEARANCE LETTER SAMPLE – UCSF TRANSGENDER CARE**

**PLEASE SEND ON OFFICIAL LETTERHEAD**

Date:

Chosen name:
Pronoun:
Legal name (if different):
DOB:
Date established care with referring provider:
Procedure sought (separate letter needed for each procedure sought):
Date or age at which patient first knew gender ID differed from birth assigned sex:
Date began living full time in identified gender (if applicable):
Taking hormones (Y/N):
Date hormones started:
City, state of primary residence:
Stable, permanent housing (Y/N):
Postoperative recovery plan (who will care for patient before and after surgery, take patient to and from surgery. Lack of housing or support does not necessarily prevent surgery. if such support is lacking, our team can work with the referring provider to identify additional sources of support for successful surgery):

To Whom It May Concern:

Patient name is a patient under my care. patient name has a gender identity of (gender identity) which is well established and stable. By my independent evaluation, I have diagnosed her/him/them with Gender Dysphoria (ICD-10 F64.1/F64.9). She/he/they reports symptoms of anxiety and depression, which she/he/they feels are exacerbated by this Dysphoria. She/he/they relates much of her/his/their Gender Dysphoria to her/his/their (specific physical characteristic – separate letter needed for each procedure). Patient name has expressed a persistent desire for procedure. She/he/they has sufficient social support to move through the surgical process. I believe patient name would benefit greatly both medically and psychologically from procedure. This procedure has been defined as medically necessary by the World Professional Association for Transgender Health.

Additionally, patient name is medically stable for surgery. Her/his medical history is unremarkable (or list any relevant medical conditions and verify that they are reasonably well controlled), making her/his/their an excellent candidate for surgery. Her/his BMI is \_\_\_\_ (required <32 for surgery). She/he/they 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.

Patient name has met the WPATH SOCv7 criteria for surgery. I feel she/he/they has capacity to provide informed consent for procedure, and that she/he/they 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,

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:

Lic:

NPI:

DEA:
Clinic name:
Address:
Phone number:
E-Mail