**Client/Patient Demographics**

Name: Click or tap here to enter text.

Legal name if different: Click or tap here to enter text.

Pronouns: Click or tap here to enter text.

DOB: Click or tap here to enter text.

Address: Click or tap here to enter text.

Phone: Click or tap here to enter text.

Clinician Name: Click or tap here to enter text.

Office/Agency location or clinic: Click or tap here to enter text.

Phone number of clinician: Click or tap here to enter text.

Are you licensed? [ ]  Yes [ ]  No (Assessments must be completed or attested to by a licensed providers.)

Please describe your experience completing assessments for gender related surgeries:

Click or tap here to enter text.

This is a:

[ ]  Single assessment or first assessment (breast or chest surgery requires one assessment)

[ ]  Second assessment (hysterectomy, oopherectomy, orchiectomy, vaginoplasty, vulvoplasty, metiodioplasty, phalloplasty requies two assessments)

For which surgery/surgeries are you referring your client?

[ ]  Orchiectomy

[ ]  Hysterectomy/Oophorectomy

[ ]  Vaginoplasty/Vulvoplasty

[ ]  Breast augmentation

[ ]  Mastectomy with chest reconstruction

[ ]  Phalloplasty

[ ]  Metoidioplasty

[ ]  Facial gender confirmation

[ ]  A surgery not listed here. Please describe: Click or tap here to enter text.

Please list the dates that you evaluated this client for readiness and appropriateness for surgical intervention:
Click or tap here to enter text.

Please give a description of this client, identifying characteristics, age, ethnicity, language, gender identity, etc., and their history of gender dysphoria and emphasize their attempts to address their gender dysphoria.
Click or tap here to enter text.

Please indicate the length of time your client has taken hormones. How do they describe their response to hormones? (e.g., decreased dysphoria, could not tolerate them, etc.)
Click or tap here to enter text.

For patients considering vaginoplasty, orchiectomy, hysterectomy, metoidioplasty, and phalloplasty: The Standards of Care states that the client must have “12 continuous months of living in a gender role that is congruent with their gender identity.” Please describe how the client has met this standard:
Click or tap here to enter text.

Please describe your rationale for the referral for surgery at this time:
 Click or tap here to enter text.

Does this client have the capacity to give informed consent for surgery? If no or limitations, please explain:
Click or tap here to enter text.

Are there issues the surgeon(s) need to know about regarding communication? These could include English fluency, hearing impairments, autism spectrum, literacy level, learning differences, etc.:
Click or tap here to enter text.

For *each* surgery your client is requesting, please describe how each surgery will improve your client's functioning. How will it make their life better? Please use the client's words:
Click or tap here to enter text.

If client is referred for facial gender confirmation, please specify how dysphoria related to their facial features affects their daily life and what impact that has on the client’s potential or current psychiatric comorbidities. Please use client’s words and be very specific:
Click or tap here to enter text.

Describe how your client has approached educating themselves about the surgery/surgeries they are seeking (e.g., spoke with peers, attended patient education session at OHSU, internet research, prior consult with a surgeon, explanation by PCP, etc.):
Click or tap here to enter text.

Does your client have a mental health diagnosis or history that the stress of surgery, anesthesia, or recovery that may cause your client to have an exacerbation of symptoms or become destabilized? For instance: PTSD, anxiety disorders, depression, bipolar disorder, schizophrenia, substance abuse, etc.:
Click or tap here to enter text.

Please describe how you have prepared your client for this possibility and how this will be addressed:
Click or tap here to enter text.

Please list all medications that the client is currently taking related to psychological concerns, sleep, or emotional problems (this should include supplements, like St. John's Wort and medical marijuana). *Please list the prescriber’s name next to the medication.*Click or tap here to enter text.

Please describe current and past substance use, including nicotine. Please list any concerns you or the client has regarding their substance use or their sobriety and any implications of using pain medication:

Click or tap here to enter text.

Nicotine can cause some surgeries to be canceled. What is your client’s plan to stop nicotine use prior to surgery? Do you believe the plan is realistic? What services were they offered to assist them?

Click or tap here to enter text.

Substance use can cause problems related to anesthesia and pain control. If the patient uses substances, including alcohol, what is the plan to reduce or stop substance use before surgery? Do you believe the plan is realistic? What services were they offered to assist them?
Click or tap here to enter text.

Please describe your client’s plan for housing following surgery. Will they be staying in their own home or recovering elsewhere? Does this recovery environment include access to a clean and private bathroom? Does the recovery environment have stairs to access the living space or stairs within the living space that could create barriers to recovery?
Click or tap here to enter text.

Describe your client's support system (relationships, family support, etc). Who will help the patient during their recovery and how long will they be available in person following hospital discharge?
Click or tap here to enter text.

Do you believe your client is capable of carrying out their aftercare plan, (including providing for their own self-care following surgery (e.g., dilation 3x per day, hygiene issues, monitoring for infection, getting adequate nutrition, staying housed, paying bills, etc.)? [ ]  Yes [ ]  No

What additional care might your client need and how will that be arranged?
Click or tap here to enter text.

**Please indicate by checking each box below that you discussed these issues to you and your client's satisfaction:**

Potential alterations in sexual functioning
[ ]  Risks and benefits of surgery and alternatives to surgery
[ ]  The impact of smoking, drugs, and alcohol on surgery and surgical outcomes
[ ]  The experience and impact of pain physically and/or emotionally
[ ]  The importance of aftercare related to post-operative complications and aesthetic outcomes
[ ]  Limits to fertility and reproductive choices (Hysterectomy, oophorectomy, orchiectomy, and genital surgeries only)

Do you believe your client has realistic expectations regarding surgery as far as:
Aesthetic outcome of surgery and impact on dysphoria? [ ]  Yes [ ]  No
Functional outcome following surgery? [ ]  Yes [ ]  No
Potential for complications? [ ]  Yes [ ]  No
Level of support needed during recovery? [ ]  Yes [ ]  No
Erotic sensation and sexual function? [ ]  Yes [ ]  No [ ]  Not applicable

Is there anything you would like to add?
Click or tap here to enter text.

Your name, title and license: Click or tap here to enter text.

Your signature: Date: Click or tap here to enter text.
Your phone number for follow up: Click or tap here to enter text.

Supervisor name, title and license: Click or tap here to enter text.
**Attestation: I have reviewed the assessment and concur with the recommendations as stated.**

Supervisor signature (if applicable):