***Therapist Information:***

|  |  |
| --- | --- |
| **Name and credentials:** | Click here to enter text. |
| **Address:** | Click here to enter text. |
|  |  |
| **Email:** | Click here to enter text. |
| **Telephone:** | Click here to enter text. |
| **Fax:**  | Click here to enter text. |

**Please describe your experience in working with gender diverse and transgender youth and your treatment philosophy (ex: relevant trainings, number of years, number of patients, any standards of care observed):** Click here to enter text.

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***Patient Information***

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| --- | --- | --- | --- |
| **Legal Last Name:** | Click here to enter text. | **Legal First Name:** | Click here to enter text. |
| **Preferred Name:** | Click here to enter text. | **Gender Pronouns:** | Click here to enter text. |
|  |  |  |  |
| **Date of Birth:** | Click here to enter text. | **Age:** | Click here to enter text. |
|  |  |  |  |
| **Sex assigned at birth:** | Click here to enter text. | **Gender Identity:** | Click here to enter text. |
|  |  |  |  |
| **Length of Treatment:** | Click here to enter text. | **Frequency of Visits** | Click here to enter text. |
|  |  |  |  |
| **Release of Information Signed:** | Click here to enter text. | **If yes, please attach.** |  |
|  |  |  |  |  |  |  |

**Please describe the patient’s gender exploration history (ex: when did they begin to explore their gender, what challenges and supports have they encountered, what are their hopes for affirming their gender in the future):** Click here to enter text.

**Please briefly summarize the patient’s mental health history, including how gender dysphoria may have impacted mental health (ex: treatment history, recent changes, coping skills and supports, plans to support safety)** Click here to enter text.

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| **Does the patient meet the criteria for a diagnosis of gender dysphoria?** Click here to enter text. |  |

**Gender Dysphoria in Adolescents and Adults (per the DSM-5):**

**A marked incongruence between one’s experienced/expressed gender and assigned gender, of at least six months’ duration, as manifested by at least two or more of the following**:

* A marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
* A strong desire to be rid of one’s primary and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
* A strong desire for the primary and/or secondary sex characteristics of the other gender
* A strong desire to be of the other gender (or some alternative gender different from one’s assigned gender)
* A strong desire to be treated as the other gender (or some alternative gender different from one’s assigned gender)
* A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one’s assigned gender)

**Do you believe this patient could benefit from evaluation or resources around Autism Spectrum Disorder? If so, please elaborate.** Click here to enter text.

**What benefits do you believe the patient would experience as a result of pursuing gender-affirming medical care?** Click here to enter text.

**What recommendations would you like to share for resources and supports as this patient seeks gender-affirming medical care? (ex: ongoing individual therapy, consult for mental health medication, DBT group, peer support group, etc.)** Click here to enter text.

**Any other comments/considerations?** Click here to enter text.

|  |  |
| --- | --- |
| **Signature:** |  |
| **Date:** |  |