DATE

DOCTOR INFORMATION

RE: NAME

DOB: MM/DD/YYYY

Dear [NAME]:

This letter is in support of FIRST NAME. (aka: LEGAL NAME ) LAST NAME's request for [SPECIFY SURGERY] Mr. NAME has been evaluated by PROVIDER and is found to fully meet the criteria for Gender Dysphoria (ICD-10 F64.9). This condition means that Mr. NAME identifies as a man and is most comfortable living in society as male and that he experiences significant emotional distress due to his gender dysphoria and his body not aligning with his identity. He has already been living for a significant number of years as male and has had good results from his hormone treatments in his secondary sex characteristic development.

Mr. NAME is in primary care and receives hormone treatment under the guidance of NAME, MD/DO/NP/PA. Ms NAME has taken cross sex hormones for over [#] years, to assist in his gender affirmation. Mr. NAME has considered seriously the implications of SURGERY and the alternatives and there is not found any impairment in his ability to make this decision at this time. It is felt that Mr. NAME will experience significant emotional relief through this procedure.

At this time Mr. NAME appears to be a good candidate for SURGERY, provided you find him medically able to undergo the procedure. He will continue to be followed in her care.

Please contact me at (123) 456-7890 if you need to discuss this patient further.

Thank you for your care of this patient.

Sincerely,

NAME, CREDENTIALS