DATE NOW

DOCTOR NAME AND ADDRESS

RE: PATIENT NAME AND DOB

Dear Dr. Ganor:

I am writing on behalf of my client **NAME** (name with insurance, if different **AKA: CLIENT FIRST) LAST**, whom I would like to refer for your consideration for a sex reassignment mastectomy. **CLIENT** has had a mental health evaluation and continues to be followed through with our Team. **CLIENT** has been known by this clinician since **00/00/0000.**

This client identifies as **[gender identity]** both socially and psychologically. It is my opinion that **CLIENT (DOB 00/00/00),** meets the criteria for Gender Dysphoria (ICD-10 F64.0). The only effective treatment for this condition is a combination of psychotherapeutic and medical intervention to enable them to live as **[gender identity]—**the role in which they most comfortably and effectively function.

CLIENT presents full time as **[gender identity]** and has presented so for the past **AMOUNT** years. They have expressed a strong desire to have chest reconstruction to enhance their successful transition to a more masculine presentation. **CLIENT's support system is/are** aware of their gender identity and **is/are** supportive of their gender transition.

CLIENT has demonstrated a good understanding of the risks involved with their medical gender affirmation, including the effects of surgical interventions. They have demonstrated an ability to responsibly maintain their health and care for their body even in the presence of the distress their gender dysphoria causes them.

IF WRITTEN BY THE PCP INCLUDE:

[Start date and duration of patient's hormone treatment (or if not on a hormone regimen, explain why), the overall duration of care between the PCP and the pt, and their history of keeping up with daily routine, follow-ups, med compliance, etc.

Please also include a description of the patient's BMI, their weight loss program and goals (if BMI is higher than surgeon's cutoff), and smoking status (never smoker, date of smoking cessation, or plan for smoking cessation).]

It is this provider's opinion that **CLIENT** is a good candidate for sex reassignment mastectomy and male chest reconstruction provided you find them medically fit. If you would like to discuss their case in more detail, please call me at **(617) 927-0000.**

Sincerely,

CLINICIAN NAME, CREDENTIALS