TLDEF
Transgender Legal Defense & Education Fund

Trans Health Project

Working for Transgender Equal Rights

Breast augmentation for gender dysphoria - Mental health professional checklist

Use this checklist to ensure that each element is included in your letter. Use language that is client specific; do not simply copy this checklist.

Identification of the procedure and diagnosis (per WPATH SOC p. 28)

☐ The client's general identifying characteristics (describe their appearance, to prevent letter swapping)
☐ The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date
☐ Results of the client's psychosocial assessment, including any diagnoses
☐ Procedure needed

Narrative account of gender dysphoria

☐ Show "Persistent, well-documented gender dysphoria" (SOC p. 59)
☐ If the patient is nonbinary, explain their chest dysphoria or gender goals
☐ Narrative of the person's trans history, including hormone use
☐ WPATH SOC p. 59 states: "Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results." If the patient has not had 12 months of hormone therapy, explain why a delay would either likely not result in additional growth (e.g., due to age) and/or would exacerbate the patient's gender dysphoria. Or if hormones are not appropriate for the person at all, explain why that is clinically appropriate for that person due to gender goals or medical contraindication.
☐ Narrative of symptoms
☐ Long-standing desire for surgery
☐ Note any history of depression, anxiety, self-harm, alcohol/drug use, suicidality, etc. related to their gender dysphoria

Describe specific harms experienced by untreated patient

☐ Discussion of the distress that is caused by her current chest
☐ Examples of being misgendered
☐ Describe specific examples of impairment related to chest dysphoria (how they are limited presently socially, work, intimate relationships, locker rooms, swimming, etc.)
☐ Any steps the patient has taken to alleviate dysphoria such as wearing breast forms, padded bras, etc. and how that is insufficient
☐ Harms associated with not having or delaying surgery

Capacity to make a fully informed decision and to consent for treatment

☐ Capacity to make a fully informed decision (SOC p. 59)
☐ A statement about the fact that informed consent has been obtained from the patient (SOC p. 28)
☐ Show "If significant medical or mental health concerns are present, they must be reasonably well controlled" (SOC p. 59)

Statement of medical necessity

☐ Explain that WPATH criteria for surgery (p. 59) have been met.
☐ If you find it to be accurate, use the phrase "medically necessary," which is defined in insurance policies simply to mean clinically appropriate care to treat a condition in accordance with generally recognized standards of care
☐ Indicate if the surgery will help to alleviate the person's gender dysphoria

Treatment plan

☐ "A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this." (SOC p. 28)
☐ Some insurance companies require a "Treatment plan that includes ongoing follow-up and care by a qualified behavioral health provider experienced in treating gender dysphoria." You can indicate that the patient intends to continue seeing you after surgery.

State the qualifications of the provider

Discuss your credentials as applicable. Omit things that do not apply.

☐ Education and degree
☐ Licensure
☐ Length of time & experience working with/diagnosing trans patients
☐ Number/percentage of trans patients seen, if a significant part of your practice
☐ Continuing education in the assessment and treatment of gender dysphoria;
☐ Relevant professional associations
☐ Relevant publications
☐ Relevant trainings given, courses taught
☐ Consider attaching CV if a specialist

If you need any additional information, please do not hesitate to contact me at [phone].

Sincerely,

Signature
Provider's Name
Licensing information
