Letter of Recommendation for the FTM Top Surgery® Procedure (Female to Male Gender Reassignment Chest Surgery)

We require a letter of recommendation or referral for the FTM Top Surgery® Procedure (Female to Male Gender Reassignment Chest Surgery). You may also have this form completed by your Physician or Therapist, to serve as a letter of recommendation for your chest surgery. This letter follows WPATH and Informed Consent guidelines. The organization and completeness of these letters provide Dr. Garramone an important degree of assurance that the mental health professional or primary care physician is knowledgeable and competent concerning gender identity disorders. World Professional Association for Transgender Health Standards of Care available at http://www.wpath.org/

Patient Legal Name:_____

Patient Date of Birth:_____

Patient Address:_____

Patient Telephone Number:_____

Please Complete the following checkboxes by placing a check mark where appropriate. Section A is required. Section B is recommended but not required.

Section A (required):

- ⊗ Chest Surgery is the next step in the Transition Process (the criteria for surgery have been met)
- ⊗ Patient has a well documented **diagnosis of Gender Dysphoria (ICD-10 F64.1)**
- ⊗ Patient is at least 18 years of age, or will be at the time of surgery (Dr. Garramone requires all patients be over the age of 18 years to be eligible for surgery)

Section B (recommended):

The Mental Health Professional or Primary Care Physician Documentation for Surgery Should Succinctly Specify:

- □ Patient has a persistent, well-documented **gender dysphoria** or breast dysphoria
- □ Patient has the capacity to make a fully informed decision and to consent for treatment with surgery
- □ If significant medical or mental health concerns are present, they must be reasonably well controlled (please attach separate letter describing the status)
- □ Hormone therapy is not a pre-requisite
- □ The Patient has general identifying characteristics as male, gender neutral, or gender variant.
- □ Results of the client's psychosocial assessment, including any diagnoses (please attach separate letter describing the status)
- □ The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date (please attach separate letter describing the status)
- □ A brief description of the clinical rationale for supporting the patient's request for surgery (please attach separate letter describing the status if necessary)
- □ Informed consent has been obtained from the patient regarding understanding surgery and its impact
- □ The Physician or Therapist is available for coordination of care and welcomes a phone call to establish this. (please attach separate letter describing)

I certify the above is true and correct, to the best of my knowledge, and have completed this form to serve as a recommendation and a referral for FTM Top Surgery® Procedure (Female to Male Gender Reassignment Chest Surgery) to be performed by Dr. Charles Garramone on the above mentioned patient.

Physician or Therapist Signature:_____**Date:**_____

Physician or Therapist Name:_____

Office Address:_____

Office Telephone:_____