

Informed Consent: Hormone Therapy for Male-to-Female Gender Transition

Name: _____ WID: _____

This informed consent form refers to the use of hormone therapy by persons who wish alleviate gender dysphoria through the feminization of their body with estrogen. It is used to ensure you understand the risks, benefits, and alternatives of taking feminizing hormones, what your provider will expect of you, and warning signs to look out for should adverse reactions develop.

As I'm sure you know, hormone therapy is not the only way to transition. Just as chromosomes and genitals do not define your gender identity, neither do the hormones in your bloodstream or the surgeries you choose to have. It is important to identify your goals of gender transition and discuss them with your healthcare provider to ensure hormone therapy is the right choice for you.

We encourage you to take all the time you need to ask questions, read, research, and think about how hormone therapy could affect you and your life. If any questions arise, either about this consent, or while taking hormone therapy, do not hesitate to ask your provider. You may also decide at any time to stop taking hormones. If you do, please notify your provider so we may update your medical record.

Initial

_____ I identify as having a female/feminine, and/or a gender non-conforming gender identity and wish to be treated with estrogen.

_____ I understand that the long term effects of estrogen are not well-studied or fully understood. There may be important health risks or benefits not listed in this consent form, which we have yet to identify.

_____ I understand the following potentially damaging or dangerous medical side effects of estrogen:

- Increases in the risk of blood clots resulting significant medical problems (i.e. pulmonary embolism, stroke, brain damage and/or death). This risk is increased if smoking tobacco and over age 35. It is advised not to smoke tobacco. My provider can provide smoking cessation resources if I am currently smoker.
- Increases in good cholesterol (HDL) and decreases in bad cholesterol (LDL). This may decrease my risk for heart attack and/or stroke in the future. My provider will check this prior to starting and monitor me during hormone therapy through periodic blood tests.
- Increases in blood pressure. My provider will check my blood pressure prior to starting and will monitor me during hormone therapy through periodic physical exams. If I have high blood pressure repeatedly, my provider may recommend diet, lifestyle changes or medication to get my blood pressure well-controlled.
- Increases in liver enzymes indicating liver inflammation or a back-up of liver products in the bile ducts. This can cause upper abdominal pain and/or liver toxicity. My provider will check me for liver issues prior to starting and will monitor me during hormone therapy through periodic blood tests.

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- Increases in migraine headaches. If severe or prolonged, I will bring this to my provider's attention.
- Increases in nausea and vomiting, similar to morning sickness during pregnancy. If severe or prolonged, I will bring this to my provider's attention.
- Increases in the risk of developing osteoporosis (thinning of the bones) that may worsen I undergo orchiectomy and stop taking hormones. My provider may recommend supplements, certain foods, and/or exercise to counter this risk. Once at a certain age or if I experience an increase in bone fractures, my provider may refer me for a bone density scan and/or medication to increase bone density.
- Possible increases in risk of developing breast cancer. My provider may recommend periodic breast exams and/or mammograms.
- Possible increase in prolactin levels, and/or formation of pituitary tumor. My provider may check my prolactin level prior to starting and monitor it during hormone therapy through periodic blood tests. If elevated, my provider may recommend decreasing or discontinuing my hormone therapy and/or refer me for a brain MRI to determine if I have a pituitary tumor.
- Mood changes. If I experience increased depression, anxiety, or feelings of suicidality, I will tell my provider so that clinic staff can assist in finding resources and supporting me.

___ I understand that estrogen may cause the following permanent changes:

- Breast growth, although there is an extreme variation in size
- Up to 40% shrinkage in the size of testicles.

___ I understand that estrogen may cause the following reversible changes. These may change back if I stop:

- Less acne
- Slowing of hair loss, especially at the temples and crown of head
- Softer skin
- Finer body hair, although it will not go away
- Less noticeable body odor and a change in the quality of the sweat from the armpits
- Decrease fat in the abdomen
- Increased fat in the buttocks and thighs
- Decreased or loss of morning and spontaneous erections
- Inability to obtain an erection hard enough for intercourse
- Decreased sex drive

___ I understand that feminizing hormone therapy will NOT:

- Eliminate hair follicles
- Change bone structure
- Change vocal pitch
- Change height
- Protect against sexually transmitted diseases

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___ I understand that feminizing effects of estrogen may take several months to become noticeable, and up to five or more years to reach their maximum and that everyone's rate of change is different. There is no way to definitely predict how or how fast my body will change or react to hormone therapy. The right dose for me may not be the same as for someone else.

___ I understand the following effects of estrogen on fertility:

- It may make it more difficult or even impossible to have genetically related offspring in the future. I have discussed this with my provider and feel comfortable that I have made an informed decision about my equivocal future reproductive abilities.
- The amount and quality of ejaculation may change, decrease, or stop entirely. Sperm may stop maturing, but will still be present if present prior to starting hormone therapy.
- **Hormone therapy is not birth control;** if having sex with someone who can become pregnant and pregnancy is not desired, I know to use some method of birth control to prevent pregnancy.

___ I understand that hormone therapy does not prevent testicular cancer and I may need periodic testicular exams unless I undergo orchiectomy.

___ I understand that hormone therapy does not prevent prostate cancer and I may need periodic screenings. Even if I undergo orchiectomy and/or vaginoplasty, the prostate is not removed in these procedures, and so I may need to continue to need periodic screenings.

___ I understand that hormone therapy may make it necessary to have more healthcare screening tests than others of my age. I agree to periodic physical examinations and blood tests to ensure my body is healthy while on hormone therapy.

___ I understand that if I choose an injectable form of estrogen: I am advised not to share or reuse needles as it places me at high risk for blood borne diseases like HIV/AIDS and hepatitis. I will need to demonstrate appropriate self-injection technique to a nurse or medical provider before being prescribed needles and syringes. If I have any adverse reactions, I must wait for them to wear off, which may take two to four weeks.

___ I agree that if I think I have or am developing any worrisome condition I will tell my provider. I agree that if my health care provider suspects that I may have any of these conditions, I will be evaluated for it either in an appointment, through blood tests, or through a referral to a specialist before the decision is made to start or continue hormone therapy at a particular dose or at all.

___ I will discuss with my provider how often I will need to come in for appointments and complete blood tests so the expectations are clear.

___ I agree to take hormones as prescribed by my provider and to inform my provider of any problems or dissatisfactions I may have with the treatment. I understand that if I take

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too much estrogen, that my body may convert it into testosterone. This may slow or stop the desired effects of the hormone.

___ I understand that I can stop taking hormone therapy at any time. I also understand that my provider can discontinue treatment if there is a concern that hormones are harming me.

___ I agree that I will not share or sell prescribed hormones with anyone else, and, if I do, I am putting that person's health at risk. If I am found to be sharing or selling my medications, they will no longer be prescribed.

___ I understand that an open and honest relationship with my healthcare provider is essential to keeping me healthy and safe. I agree to tell my medical provider about any unprescribed hormones, dietary supplements, herbs, recreational drugs or medications I might be taking. Sharing this information will help my provider to prevent potentially harmful medication interaction. I understand and expect that I will never be penalized for my honesty and that clinic staff will continue to provide me with medical care, regardless of what information I share with them.

Patient Signature

Date

Witness Printed Name

Witness Signature

Date

