BEVERLY FISCHER, MD
THE ADVANCED CENTER FOR PLASTIC SURGERY

# Gender Affirming Top Surgery Letter Requirements

To proceed with surgery, our practice requires a letter from a **licensed mental health professional** experienced in the assessment of gender dysphoria/gender incongruence. All points of information are required and have been selectively sourced from WPATH standards of care.

Please note:

- Letters must be **current** (within 12 months and within 6 months for adolescents).
- Template or form letters may be rejected if required elements are missing.
- Letters must include **institution/agency letterhead**

Please provide this checklist to your therapist, psychologist, psychiatrist, PMHNP, or other qualifying licensed mental health provider.

For the purposes of this document, the providers not typically classified as licensed mental health providers (LMHPs) include general primary care physicians, RNs, and unlicensed counselors or coaches. While these professionals may support mental health, they may lack specialized state licensure for diagnosing and treating mental illness.

**1. Provider Qualifications (Required)**

The letter must clearly state:

☐ Provider's full name and professional credentials
☐ Professional license type and license number
☐ Jurisdiction (state/country) of licensure
☐ Practice address and contact information
☐ Statement confirming the provider is **licensed and in good standing**
☐ Statement confirming experience with **gender-diverse patients**

**2. Patient Identification (Required)**

☐ Patient's full legal name
☐ Patient's date of birth
☐ Duration of the therapeutic relationship
☐ Frequency of visits (e.g., weekly, monthly)

**3. Evaluation Summary (Required)**

The letter must confirm that the provider has personally evaluated the patient and include:

☐ Brief summary of the patient's gender history
☐ Duration and persistence of gender dysphoria or gender incongruence
☐ Description of how dysphoria impacts daily functioning (social, emotional, psychological)

**4. Diagnostic Statement (Required)**

☐ Statement that the patient meets diagnostic criteria for **gender dysphoria or gender incongruence**, consistent with current clinical standards
☐ Confirmation that the diagnosis is **persistent and not situational/acute**

**5. Mental Health Assessment (Required)**

The letter must address:

☐ Presence or absence of co-occurring mental health conditions
☐ Whether any conditions are **reasonably well controlled**, if present
☐ Statement that the mental health condition is not impairing the patient's ability to participate in informed decision-making or contributing to the desire to transition

**6. Capacity and Informed Decision-Making (Required)**

☐ Assessment of the patient's ability to understand:

- The nature of top surgery
- The permanent and largely irreversible nature of the procedure
- Risks, benefits, and alternatives (including no surgery or delaying surgery)

☐ Statement that the patient demonstrates **capacity to make an informed decision**

**7. Discussion of Regret and Alternatives (Required)**

☐ Confirmation that the provider discussed:

- The possibility of future regret or dissatisfaction
- Potential for change in identity or life circumstances
- Non-surgical alternatives and the option to defer surgery

☐ Statement that the patient understands these risks

**8. Support System and Psychosocial Context (Required)**

☐ Description of patient's social support system (family, friends, community)
☐ Identification of any significant psychosocial stressors
☐ Assessment of coping skills and resilience

**9. Surgical Readiness Opinion (Required)**

☐ Clear statement that, in the provider's professional opinion, the patient is psychologically appropriate for consideration of gender-affirming top surgery at this time

☐ Statement that this opinion does **not guarantee surgical satisfaction or eliminate the possibility of regret**

**10. Additional Requirements for Minors (Under 18)**

If the patient is a minor, the letter must ALSO include:

☐ Assessment of the minor's emotional and cognitive maturity
☐ Statement that the minor demonstrates developmentally appropriate understanding of the procedure
☐ Confirmation that parents/legal guardians are aware of and supportive of the decision
☐ Statement that the decision reflects **persistent gender dysphoria**, not transient distress
☐ Confirmation that alternatives, including delaying surgery until adulthood, were discussed

**11. Professional Attestation and Signature (Required)**

☐ Provider's handwritten or secure electronic signature
☐ Date of signature
☐ Statement such as:

"I attest that this evaluation reflects my independent professional opinion and is based on my direct clinical assessment of the patient."

I, the patient and/or legal parent of the patient, agree that I have read and understand the requirements of this document and will provide your practice with the letter at least two weeks before surgery takes place. Submission of a letter does not guarantee surgical approval and additional documentation may be requested based on clinical review. I understand the surgery can be cancelled without refund in the case that I cannot provide the documents required.

Patient or Legal Guardian Signature:_____ date: _____

Witness Signature:_____ date: _____