DATE

DOCTOR INFORMATION

RE: NAME

DOB: MM/DD/YYYY

Dear [NAME]:

This letter is in support of FIRST NAME. (aka: LEGAL NAME ) LAST NAME's request for [SPECIFY SURGERY] Ms. NAME has been evaluated by PROVIDER and is found to fully meet the criteria for Gender Dysphoria (ICD-10 F64.9). This condition means that Ms. NAME identifies as a woman and is most comfortable living in society as female and that she experiences significant emotional distress due to her gender dysphoria and her body not aligning with her identity. She has already been living for a significant number of years as female and has had good results from her hormone treatments in her secondary sex characteristic development.

Ms. NAME is in primary care and receives hormone treatment under the guidance of NAME, MD/DO/NP/PA. Ms NAME has taken cross sex hormones for over [#] years, to assist in her gender affirmation. Ms. NAME has considered seriously the implications of SURGERY and the alternatives and there is not found any impairment in her ability to make this decision at this time. It is felt that Ms. NAME will experience significant emotional relief through this procedure. Subsequently, Ms. NAME will benefit by the reduction in level of hormone treatment she requires after orchiectomy.

At this time Ms. NAME appears to be a good candidate for SURGERY, provided you find her medically able to undergo the procedure. She will continue to be followed in her care.

Please contact me at (123) 456-7890 if you need to discuss this patient further.

Thank you for your care of this patient.

Sincerely,

NAME, CREDENTIALS