SIDNEY BORUM JR HEALTH CENTER

Youth Gender Affirming Care BH Documentation

Therapist Information

Name			
Address	city	state	zip
Email			
Telephone	**Fax**		
Best way to contact ☐ Mail ☐ Email ☐ Telephone ☐ Fax			
Best time to contact ☐ Morning ☐ Afternoon ☐ Early Evening ☐ Other (please specify):			
Are you able to complete the attached questionnaire? ☐ Yes ☐ No *If no, please complete this page, and return as described at the end of this document.*			
Do you plan to continue to see this patient at this time? ☐ Yes ☐ No			

Patient Information

Full Name, as listed on insurance or identity documents	
Name Used	**Pronouns**
Date of Birth	**Age**
Gender Identity	**Sex Assigned at Birth**
Length of Treatment	**Frequency of Visits**
Release of Information Signed? ☐ Yes ☐ No *If yes, please attach.*	

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Please complete the below questionnaire. If additional space is needed, you are welcome to attach additional documentation, or respond to these questions in a separate document. If you have any questions, contact information can be found at the end of this questionnaire.

1. **Please describe the patient's experience with gender** (ex: when did they begin to explore their gender, what challenges and supports have they encountered so far).

2. **What are this patient's hopes and expectations for affirming their gender?**

3. **Who actively supports the patient in their gender affirmation?** (ex: specific family members, friends, school, online supports, faith community, community groups, professional helpers, etc.)

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4. **What has this patient's experience of puberty been like?** If they have not started puberty, what is their experience thinking about puberty in the future?

5. **What is this patient's experience of school and other social spaces?**

6. **How would you describe the parent(s)/guardian(s) readiness for the patient to access gender affirming care? Are there particular supports you anticipate parent(s)/guardian(s) or other family members needing or benefiting from?**

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7. **What cultural considerations may be helpful to be aware of when working with this patient, including factors that may be supportive or challenging to their gender affirmation?** (ex: religion, race, culture, and other dimensions of diversity)

8. **What are strengths of this patient that you would like to highlight?**

9. **What are some potential barriers to care?** (ex: lack of parental consent, transportation to appointments, insurance coverage, uncertainty about desired interventions, etc.)

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10. **What coping skills and resources has the patient developed to address potential barriers?**

11. **Please describe the patient's mental health history, including how gender dysphoria may have impacted mental health if applicable** (ex: treatment history, recent changes, coping skills and supports, plans to support safety).

12. **Does the patient meet the criteria for a diagnosis of gender dysphoria?** ☐ Yes ☐ No ☐ Unsure

13. **If applicable, how does the patient manage their experience of gender dysphoria or gender incongruence?**

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14. **Are there things that may impact the patient's experience of or ability to describe their gender identity or gender affirmation goals? If so, please elaborate.** (ex. anxiety, neurodiversity, mistrust of providers, etc.)

15. **What benefits do you believe the patient would experience as a result of pursuing gender affirming medical care?**

16. **What, if any, concerns do you have about this patient pursuing gender affirming medical care?**

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17. **What recommendations, if any, would you like to share for resources and supports as this patient seeks gender affirming medical care?** (ex: ongoing individual therapy, consult for mental health medication, peer support, etc.)

18. **Any other comments?**

Signature ▲ **Date**

Thank you for your time.

If you have any questions, please contact	**At** (Contact option 1)	**Or** (Contact option 2)
Return by		
Use a secure email program to scan and email to	**Fax to**	
Address city	state	zip