**MEDICAL CLEARANCE LETTER SAMPLE – PLEASE SEND ON OFFICIAL LETTERHEAD**

**CNE Breast Health Center Gender-Affirming Care**

Date:

Chosen name:  
Pronoun:  
Legal name (if different):  
DOB:  
Date established care with referring provider:  
Procedure sought (Specify desired surgery): Mastectomy w/without creation of male chest/ Breast augmentation  
Date or age at which patient first knew gender ID differed from birth-assigned sex:  
Date began living full time in identified gender (if applicable):  
Taking hormones (Y/N):  
Date hormones started:  
City, state of primary residence:  
Stable, permanent housing (Y/N):  
Postoperative recovery plan (who will help care for patient before and after surgery, take patient to and from surgery):

Lack of housing/support does not necessarily prevent surgery, but if it is lacking, our team can work with the referring provider to identify additional resources for successful surgery)

To Whom It May Concern:

Patient name is a patient under my care. patient name has a gender identity of (gender identity) which is well established and stable. By my independent evaluation, I have diagnosed her/him/them with Gender Dysphoria (ICD-10 F64.1/F64.9). She/he/they reports symptoms of anxiety and depression, which she/he/they feels are exacerbated by this Dysphoria. She/he/they relates much of her/his/their Gender Dysphoria to her/his/their (specific physical characteristic – separate letter needed for each procedure). Patient name has expressed a persistent desire for specific top surgery procedure. She/he/they has sufficient social support to move through the surgical process. I believe patient name would benefit greatly both medically and psychologically from procedure. This procedure has been defined as medically necessary by the World Professional Association for Transgender Health (WPATH).

Additionally, patient name is medically stable for surgery. Her/his medical history is unremarkable (or list any relevant medical conditions and verify that they are reasonably well controlled), making her/his/their an excellent candidate for surgery. Her/his BMI is \_\_\_\_ (required <35 for surgery). She/he/they does not smoke cigarettes or drink excessive alcohol, and is not at risk of or an active user of illicit drugs or drugs of abuse.

Patient name has met the WPATH SOCv7 criteria for surgery. I feel she/he/they has capacity to provide informed consent for major surgery, and that she/he/they is ready, appropriate and medically clear for this procedure. I hereby recommend and refer patient name for this surgery. Please feel free to contact me with any questions or concerns.

Sincerely,

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

License: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI: DEA: \_\_\_\_

Clinic name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Excerpt from: The Standards of Care VERSION 7**

**World Professional Association for Transgender Health**

**Criteria for Breast/Chest Surgery (One Referral)**

**Criteria for mastectomy with or without creation of a male chest in FtM patients:**

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents)
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.
5. Hormone therapy is not a prerequisite.

**Criteria for breast augmentation (implants/lipofilling) in MtF patients:**

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is often recommended that MtF patients undergo feminizing

hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to

maximize breast growth in order to obtain better surgical (aesthetic) results.

*(The CNE Breast Health Center surgeons do not require prerequisite hormone therapy, however if you prefer to use medical insurance coverage for your procedure, please review your own specific policy as many insurance companies- including BCBS of RI and RI Neighborhood Health Plan- do require prior hormone therapy.)*