Trans Care BC
Provincial Health Services Authority

Surgical Readiness Assessment

Template – Upper Surgery or Gonadectomy

PATIENT INFORMATION			
Last name:		Name used:	
Name *(as appears on BC Services Card):*		Pronouns:	
PHN:	Date of birth *(YYYY-MM-DD):*	☐ Under 18yrs?	
Address:			
City:	Province:	Postal code:	
Phone: Voicemail ok? ☐ *Yes* or ☐ *No*		Email:	
Primary language: Interpreter required? ☐ *Yes* or ☐ *No*			
Emergency contact name:	Emergency contact phone:		
Any considerations regarding appointment booking?			

PROVIDER DETAILS				
Provider name:		I am the client's primary care provider	MSP #:	
Clinical discipline:			Office phone:	
Mailing address:			Office fax:	
City:	Province:	Postal code:	Email:	
Name of client's primary care provider (if different):		Primary care provider phone:	Primary care provider fax:	
Other care providers involved *(e.g., specialists, support workers, mental health team):* *Please list name(s), organizations, phone numbers.*				

CLINICAL INFORMATION

Please list the dates you met with your client to discuss gender-affirming surgery: ☐ Client seen via telehealth

1. For which surgery or surgeries are you referring your client? *Select all that apply.*

UPPER SURGERY
- ☐ Chest reduction & construction *(mastectomy & contouring)*
- ☐ Breast construction *(augmentation)*

GONADECTOMY
- ☐ Hysterectomy *(with or without oophorectomy)*
- ☐ Orchiectomy *(with or without scrotectomy)*

OTHER
- ☐ Other surgery:

2. Please describe your client's gender identification, their experience of gender incongruence/dysphoria, and the impact of any other gender-affirming steps taken to date *(e.g., hormone therapy, hair removal, name change):*

3. Has your client taken hormones? If so, please describe details of treatment below:
Please list start date, duration, significant breaks. Please note if hormone therapy is not clinically indicated.

4. Summarize your patient's expectations regarding surgery:

5. Are there any communication or accessibility needs the surgeon should be aware of *(e.g., interpreter, visual/audio aids, support person/worker)?*

6. Provide a brief description of your client's past and current medical history, including:

a. Physical health: *List any diagnoses, treatment history and current status.*

Height: **Weight:** **BMI:** ☐ **Sleep apnea** – If checked: CPAP therapy? ☐ *Yes* or ☐ *No*

b. Mental health: *List any diagnoses, treatment history and current status.*

c. Surgical history:

d. Current medications: *Attach list if available.*

e. Please indicate if your client has past/current substance use that would affect their perioperative experience: *If yes, please describe below.* ☐ *Yes* or ☐ *No*

f. Allergies:

7. Describe your client's social situation *(e.g., housing, work, supports):*

8. Do you anticipate your client will have stable housing and adequate support to facilitate healing during the post-op period? *If no, please explain how this will be managed below.*

☐ *Yes* or ☐ *No*

9. Do you believe your client is capable of carrying out their after care plan *(e.g., reducing activities, managing drains/compression vest)? If no, please explain how this will be managed below.*

☐ *Yes* or ☐ *No*

10. Briefly summarize your conversation with the patient regarding impacts to fertility and/or infant feeding:

11. Briefly summarize your recommendation:

REVIEW OF WPATH STANDARDS OF CARE 8 CRITERIA

The following criteria are applicable to ALL gender-affirming procedures:

☐ I confirm that I have reviewed with the client the procedure(s) indicated above.

☐ I confirm this client's gender incongruence/dysphoria is marked and sustained.

☐ I confirm the client meets diagnostic criteria for gender incongruence/dysphoria and have excluded other possible causes of apparent incongruence.

☐ I confirm this client understands the information provided and has the capacity to consent to the treatment(s) outlined above. If the client is under 19 years of age, I confirm that in my opinion, they have the capacity to consent to treatment and treatment is in their best interest.

- "Evaluating Decision-Making Capacity for Gender-Affirming Interventions" tool available at the Trans Care BC Website *(Health Professionals – Clinical resources).*

☐ I confirm that any mental health and physical conditions that could negatively affect the outcome of treatment for this client have been assessed, with risks and benefits discussed.

☐ I confirm that the client understands the impact of treatment on reproduction and/or infant feeding and have reviewed relevant options.

CONFIRMATION OF QUALIFICATIONS

Clinicians supporting clients with decisions regarding gender-affirming medical or surgical treatments should hold specific qualifications and competencies to assess readiness for gender-affirming surgeries. WPATH SOC-8 suggests providers liaise with professionals from different disciplines for consultation and referral, when required.

☐ I confirm that I hold the following qualifications and competencies:

- I have a Master's degree or equivalent training in a clinical field relevant to this role.
- I am licensed by a statutory body.
- I am able to identify mental health or psychosocial concerns and distinguish these from gender incongruence, dysphoria or diversity.
- I am able to assess capacity to consent.
- I have experience or am qualified to assess clinical aspects of gender incongruence, dysphoria and diversity.
- I engage in ongoing professional development relating to gender incongruence, dysphoria and diversity.

☐ I confirm that I hold the following additional competencies for working with youth: *(if relevant)*

- I have theoretical and evidenced-based training and expertise in general child, adolescent, and family mental health across the developmental spectrum.
- I have training and expertise in gender identity development, gender diversity in children and adolescents and possess general knowledge of gender diversity across the lifespan.
- I have training and experience in autism spectrum disorders and other neurodevelopmental presentations, or I collaborate with a developmental disability expert when working with autistic/neurodivergent gender diverse adolescents.
- I engage in ongoing professional development in all areas relevant to gender diverse children, adolescents, and families.

Select one:

☐ I am competent using ICD (or alternative) to diagnose gender incongruence/dysphoria.

- A diagnosis of gender incongruence/dysphoria is required prior to gender-affirming medical or surgical treatments.
- Any physician or nurse practitioner is qualified to make these diagnoses, although some may feel they lack relevant training and experience.

☐ I am a clinician whose scope of practice does not include the ability to diagnose gender incongruence/dysphoria. However, I have experience care planning for clients seeking gender-affirming medical or surgical interventions and providing recommendations for treatment. If needed, I will assist my client in connecting with a clinician who is qualified to diagnose gender incongruence/dysphoria.

Healthcare providers can use the RACEapp+, eCase, or call the RACE Line at 604-696-2131 (toll-free: 1-877-696-2131) and select the "Transgender Health" option to consult with an experienced clinician.

CLINICIAN SIGNATURE

The above information is true to the best of my knowledge. I am available for coordination of care if needed.	Clinician signature:	Date (YYYY-MM-DD):
I confirm this person meets criteria for gender incongruence based on this assessment.	MD/NP signature (if needed):	Date (YYYY-MM-DD):