

ANNEX B

INFORMED CONSENT FORMS:

TRANSWOMAN [MtF] ANTIANDROGEN TREATMENT B(1)

TRANSWOMAN [MtF] ESTROGEN TREATMENT B(2)

TRANSMAN [FtM] TESTOSTERONE TREATMENT B(3)

YOUNG PERSON [FtM] HORMONE BLOCKING TREATMENT B(4)

YOUNG PERSON [MtF] HORMONE BLOCKING TREATMENT B(5)

TRANSWOMAN [MtF] LIMITED GENDER CONFIRMATION SURGERY B(6)

TRANSWOMAN [MtF] GENDER CONFIRMATION SURGERY B(7)

TRANSMAN [FtM] GENDER CONFIRMATION SURGERY B(8a)

TRANSMAN [FtM] REFUSAL OF P.V EXAMINATION/POSSIBLE CONSEQUENCES B(8b)

INFORMED CONSENT for ANTIANDROGEN TREATMENT
(may be used in conjunction with NHS consent form)
(Trans woman)

.....
[Print name in full]
[address]
.....
.....
..... [postcode]

I agree that I have had the implications of taking ANTIANDROGEN medication explained to me in full by (name of clinician). I have had this Form for at least 4 weeks. The examinations which the clinician wishes me to undergo prior to starting hormone therapy, and the reasons for those examinations have been explained to me. I understand why it is necessary and beneficial to have those examinations before being prescribed hormone treatment. The consequences of not undertaking any of those examinations have been explained to me. I have chosen not to have the following examination(s):

I have had the opportunity to discuss the effects of Goserelin, Antiandrogen Cyproterone Acetate (CPA), or other antiandrogen treatment (.....)with my clinician, and to clarify any points I did not understand.

Effect of Hormones

I identify as **female** and will, therefore be treated initially with antiandrogens. As a result, I expect to experience decreased fertility and testicular size, decreased libido and less frequent, less firm erections. Most of these changes are reversible when I stop taking the medication. However, I understand that reproductive capacity may be limited after treatment and that, therefore, I may be unable to have genetically related children in the future. (delete as appropriate) [Therefore, I have already banked sperm] or [Having been fully informed of the option to bank sperm, and having been given specific information regarding local, private or NHS facilities suitable for storage, I have decided not to take up this option. I understand that if I have not made use of those facilities before treatment is undertaken, I may be unable to do so later through infertility]

Potential Risk Factors

I understand that I will be at increased health risk if any of the following pre-existing factors apply: cigarette smoking; obesity; advanced age; heart disease; hypertension (high blood pressure); clotting abnormalities; malignancy (cancer); endocrine abnormalities; alcohol and/or drug misuse.

(Mimms and BNF should be consulted for additional information regarding contra-indications of specific medications)

- I understand that, after orchidectomy, it will no longer be necessary to take antiandrogens in the long term, although a short course of a few months may be necessary to overcome any beard re-growth owing to pre surgery withdrawal of hormones.
- I agree to take the hormones in the dosage prescribed by my clinician and undertake not to take additional doses as this will pose an extra health risk.
- I understand that other medication available on or off prescription may be contra-indicated whilst I am on CPA medication.
- I agree to my CPA treatment being monitored by my clinician.
- I am over 16 years old.

Signed date
[individual undergoing hormone treatment]

see over

I (Clinician) am satisfied that(patient) understands the nature of the proposed treatment and has a full appreciation of the consequences of both the treatment in terms of intended and possible side-effects and, also, the possible consequences of not undergoing this treatment.

-
- (n.b. It is inappropriate and may be considered misconduct for any medical specialist to assume that a patient who opts for gamete storage, or has already done so, is in any way equivocal about, or not committed to, the transition process.)

Signed date
(clinician)

INFORMED CONSENT for HORMONE TREATMENT

(may be used in conjunction with NHS consent form)

(Trans woman)

.....
[Print name in full]

[address]

.....

.....

.....

..... [postcode]

I agree that I have had the implications of taking OESTROGEN treatment (in conjunction with antiandrogens – delete if not applicable) explained to me in full by (name of clinician). I have had this form for at least 4 weeks. The examinations which the clinician wishes me to undergo prior to starting hormone therapy, and the reasons for those examinations have been explained to me. I understand why it is necessary and beneficial to have those examinations before being prescribed hormone treatment. The consequences of not undertaking any of those examinations have been explained to me. I have chosen not to have the following examination(s):

-

I have had the opportunity to discuss the effects of hormones with my clinician, and to clarify any points I did not understand.

Desired Effect of Hormones

I identify as **female** and will, therefore, be treated with oestrogens (possibly in conjunction with progestins or antiandrogens). As a result of taking oestrogens I expect to experience: some breast growth; some redistribution of body fat to approximate to a female pattern; decreased upper body strength; softening of skin; decrease in body hair; a slowing of the loss of scalp hair; decreased fertility and testicular size and less frequent, less firm erections. Most of these changes are reversible, but breast enlargement will not completely reverse after treatment is discontinued. Where that is the case, the remaining breast tissue can only be removed surgically.

I understand that reproductive capacity may be limited after treatment and that, therefore, I may be unable to have genetically related children in the future. (delete as appropriate) [Therefore, I have already banked sperm] or [Having been fully informed of the option to bank sperm, and having been given specific information regarding local, private or NHS facilities suitable for storage, I have decided not to take up this option. I understand that if I have not made use of these facilities before treatment is undertaken, I may be unable to do so later through irreversible infertility]

I understand that the full physical impact of taking hormones may not be evident until two years of continuous treatment have been undergone.

Potential Negative Medical Side Effects

I understand that treatment with oestrogens and progestins may increase the risk of: venous thrombosis (and, therefore, the risk of pulmonary embolism); benign pituitary prolactinoma (tumour), infertility; weight gain; mood swings; liver disease; gallstones; breast cancer; hypertension (high blood pressure) and diabetes mellitus.

I understand that I will be at increased risk of unwanted side effects if any of the following pre-existing factors apply: cigarette smoking; obesity; advanced age; heart disease; hypertension (high blood pressure); clotting abnormalities; malignancy (cancer); endocrine abnormalities; alcohol and/or drug misuse.

(Mimms and BNF should be consulted for additional information regarding contra-indications of specific medications)

- I understand that, after orchidectomy (removal of testes), I will no longer be treated with antiandrogens but that a lifelong maintenance dose of oestrogens is almost certain to be required to maintain feminisation and protect against osteoporosis.
- I agree to take the hormones in the dosage prescribed by my clinician and undertake not to take additional doses of oestrogens as this will pose an extra health risk.
- I understand that other medication available on or off prescription may be contra-indicated whilst I am on hormone medication.
- I agree to my hormone treatment being monitored by my clinician.
- I am over 16 years old.

Signed date

(individual undergoing hormone treatment)

I (Clinician) am satisfied that(patient) understands the nature of the proposed treatment and has a full appreciation of the consequences of both the treatment in terms of intended and possible side-effects and, also, the consequences of not following this treatment.

- (n.b. It is inappropriate and may be considered misconduct for any medical specialist to assume that a patient who opts for gamete storage, or has already done so, is in any way equivocal about, or not committed to, the transition process.)

Signed date
(Clinician)

INFORMED CONSENT for HORMONE TREATMENT

(may be used in conjunction with NHS consent form)

[Trans man]

.....
[Print name in full]

[address]

.....

.....

.....

..... [postcode]

I agree that I have had the implications of TESTOSTERONE administration explained to me in full by(name of clinician). I have had this form for at least 4 weeks. The examinations which the clinician wishes me to undergo prior to starting hormone therapy, and the reasons for those examinations have been explained to me. I understand why it is necessary and beneficial to have those examinations before being prescribed hormone treatment. The consequences of not undertaking any of those examinations have been explained to me. I have chosen not to have the following examination(s)and , therefore, in addition to this form, I have signed form B(8b):

- I have had the opportunity to discuss the effects of hormones with my clinician, and to clarify any points I did not understand.

Desired Effects of Hormones

I identify as **male** and therefore will be treated with testosterone (androgens). I understand that I can expect the following **permanent changes**: a deepening of the voice; clitoral enlargement; possibly mild breast atrophy; increased facial and body hair and male pattern baldness.

The following changes are reversible: increased upper body strength; weight gain; increased sexual arousability; and decreased hip fat. Cessation of menstruation, which normally accompanies cross-hormone administration, may or may not be reversed if hormones are ceased.

-
- I understand that reproductive capacity will be lost after treatment and that, therefore, I will be unable to have genetically related children in the future. (delete as appropriate) [Therefore, I have already opted for egg storage] or [Having been fully informed of the options to enable me to have a genetically related child ,and having been given specific information regarding local, private or NHS facilities suitable for storage, I have decided not to take up this option. I understand that if I have not made use of these facilities before treatment is undertaken, I will not be able to do so later]

I understand that the changes outlined above will start shortly after treatment is initiated, but that the full physical impact of taking hormones may not be evident until two years of continuous treatment have been undergone.

Potential Negative Medical Side Effects

I understand that treatment with androgens (testosterone) may cause the following side effects: infertility, acne, mood swings, increased risk of cardiovascular disease heart and circulatory disorders; rarely, malignant liver tumours and/or liver dysfunction; in the longer term, skin atrophy in the genital area may be experienced.

I understand that I will be at increased risk of unwanted side effects if any of the following pre-existing factors apply: cigarette smoking; obesity; advanced age; heart disease; hypertension (high blood pressure); clotting abnormalities; malignancy (cancer); endocrine abnormalities; alcohol and/or drug misuse.

I understand that little research has been done into the long term effects of these treatments with androgens (testosterone) and so the above lists may not be comprehensive.

(Mimms and BNF should be consulted for additional information regarding contra-indications of specific medications)

- I understand that, in the light of current knowledge and practice, an oophorectomy (removal of ovaries) and hysterectomy (removal of uterus and cervix) is recommended after a maximum of 5 years of androgen (testosterone) therapy. I understand that if these are not undertaken in a timely manner, then regular cervical smears are recommended because of the increased risk of cancer.
- I understand that a lifelong maintenance dose of androgens (testosterone) is likely to be required, although, a reduction in the dosage of testosterone will be considered for health reasons after oophorectomy (removal of ovaries).

- I understand that if I cease androgen (testosterone) therapy, depending on the timing of such cessation, there is a risk of developing osteoporosis unless estrogen therapy is undertaken. I understand that estrogen therapy, itself, can produce unwanted medical and physical side effects.
- I agree to take the hormones in the dosage prescribed by my clinician and undertake not to take additional doses of testosterone as this will pose an extra health risk.
- I agree to my hormone treatment being monitored by my clinician.
- I understand that other medication available on or off prescription may be contra-indicated whilst I am on hormone medication.
- I am over 16 years old.

Signed date
 (individual undergoing hormone treatment)

I (Clinician) am satisfied that(patient) understands the nature of the proposed treatment and has a full appreciation of the consequences of both the treatment in terms of intended and possible side-effects and, also, the possible consequences of failure to treat.

-
- (n.b. It is inappropriate and may be considered misconduct for any medical specialist to assume that a patient who opts for gamete storage, or has already done so, is in any way equivocal about, or not committed to, the transition process.)

Signed date
 (Clinician)

INFORMED CONSENT for HORMONE TREATMENT [reversible treatments only]

B(4)

(may be used in conjunction with NHS consent forms)

(young person: Female to Male individual)

.....
[Print name, in full, of young person undergoing treatment]

I am years & months old. Date of birth.....[dd/mm/yy]

[address]

.....

..... [postcode]

I agree that I have had the implications of hormone administration to delay the physical changes of puberty explained to me in full by(name of Clinician). I have had this form for at least six (6) weeks and have had the opportunity to discuss the effects of this treatment with my clinician, and to have points I did not fully understand, explained to me.

I identify as **male**. I understand that by taking LHRH agonists or progestins, I will block the production of estrogen and, therefore, stop menstruation (periods). This treatment will also block other effects of puberty such as breast development.

- I understand that the effects of this treatment are largely reversible when I stop taking the medication.
- I consent to undergoing this treatment. I have not been pressured to make this decision.
- I have been given advice about the effect of treatment on my ability to have a family later. I have had the opportunity to discuss reproductive options such as egg storage which might enable me to have a family later, if treatment does affect my fertility. I have also been given details of local and national, private and NHS facilities providing the storage.

Signed date

(individual undergoing hormone treatment)

If the young person undergoing treatment is under 16 years old, the form must be signed by a person exercising Parental Responsibility* for the young person named above.

I,.....(person with Parental Responsibility) agree that I have had the implications of hormone administration to block the effects of puberty, in the young person named above, explained to me in full by (name of Clinician). I have had the opportunity to discuss, with the clinician, the blocking effects of the hormones and to have points I did not fully understand, explained to me.

- I consent to..... (name of young person) undergoing this treatment

Signed date

(person with Parental Responsibility)

To be completed by the Clinician: I am satisfied that the young person named above is Gillick competent

Signed date

(Clinician)

- a person with Parental Responsibility will include the natural mother, automatically; the natural father if married to the mother at the time of child’s birth or having subsequently married her, or having a section 4[1a] Order or 4[1b] agreement (Children Act [CA] 1989); anyone with a Residence Order [s8 & s12, CA 89] or a Care Order [s31, s33(3) CA 89]; anyone appointed guardian or having an Adoption Order.
- a young person of 16 years old is regarded in law as ‘Gillick’ competent. ‘Gillick’ refers to a court case, Gillick v West Norfolk and Wisbeach Area Health Authority [1985]. Under the age of 16, it is a matter for the judgement of medical practitioners, whether the child has Gillick competence, which involves, “not merely an ability to understand the nature of the proposed treatment.....but a full understanding and appreciation of the consequences of both the treatment in terms of intended and possible side-effects and, equally important, the anticipated consequences of failure to treat”. [Re R, Lord Donaldson]

INFORMED CONSENT for HORMONE TREATMENT [reversible treatments only] B(5)

(may be used in conjunction with NHS consent forms)

(young person: Male to Female individual)

.....
[Print name, in full, of young person undergoing treatment]

I am years & months old. Date of birth.....[dd/mm/yy]

[address]

.....

..... [postcode]

I agree that I have had the implications of hormone administration to block the physical changes of puberty explained to me in full by(name of Clinician). I have had this form for at least six (6) weeks and I have had the opportunity to discuss the effects of this treatment with my clinician, and to have points I did not fully understand, explained to me.

I identify as **female**. I understand that by taking LHRH agonists or medroxyprogesterone, or antiandrogens, I will block secretion of testosterone or neutralise its action. This treatment will block the effects of puberty such as growing facial hair and a deepening of the voice.

- I understand that the effects of this treatment are largely reversible when I stop taking the medication.
- I consent to undergoing this treatment. I have not been pressured to make this decision.
- I have been given advice about the effect of treatment on my ability to have a family later. I have had the opportunity to discuss reproductive options such as sperm banking which might enable me to have a family later, if treatment does affect my fertility. I have also been given details of local and national, private and NHS facilities providing the storage.

Signed date

(individual undergoing hormone treatment)

If the young person undergoing treatment is under 16 years old, the form must be signed by a person exercising Parental Responsibility* for the young person named above.

I,.....(person with Parental Responsibility) agree that I have had the implications of hormone administration to block the effects of puberty explained to me in full by (name of clinician). I have had the opportunity to discuss, with the clinician, the effects of hormones on the young person named above, and to have points I did not fully understand, explained to me.

- I consent to..... (name of young person) undergoing this treatment

Signed date

(person with Parental Responsibility)

To be completed by the Clinician: I am satisfied that the young person named above is Gillick competent

Signed date

(Clinician)

- a person with Parental Responsibility will include the natural mother, automatically; the natural father if married to the mother at the time of the child's birth or have subsequently married her, or having a section 4[1a] Order or 4[1b] agreement (Children Act [CA] 1989); anyone with a Residence Order [s8 & s12, CA 89] or a Care Order [s31 & s33(3) CA 89]; anyone appointed guardian or having an Adoption Order.
- a young person of 16 years old is regarded in law as 'Gillick' competent. 'Gillick' refers to a court case, Gillick v West Norfolk and Wisbeach Area Health Authority [1985]. Under the age of 16, it is a matter for the judgement of medical practitioners, whether the child has Gillick competence, which involves, "not merely an ability to understand the nature of the proposed treatment.....but a full understanding and appreciation of the consequences of both the treatment in terms of intended and possible side-effects and, equally important, the anticipated consequences of failure to treat". [Re R, Lord Donaldson].

INFORMED CONSENT for GENDER CONFIRMATION SURGERY [limited]
(may be used in conjunction with NHS or hospital consent forms)
(Trans woman)

.....
[Print name in full]

[address]
.....
.....
.....
..... [postcode]

I agree that I have had the implications of gender confirmation surgery explained to me in full by the Surgeon,(name of Surgeon). I have had this form for at least eight (8) weeks and I have had the opportunity to discuss the effects of this surgery with my surgeon.

I understand that the capacity to reproduce will be lost, irreversibly, unless I have taken steps to store sperm, or I am intending to undergo surgical removal and storage of testes during surgery

I identify as **female** and I understand that my gender confirmation surgery may include orchidectomy, penectomy, labiaplasty and clitoroplasty, that is, the removal of external genitalia and the creation of a clitoris and labia minora and majora. The aim of the surgery will be to create an acceptable female cosmetic appearance and, as far as possible, to retain sexual sensation. I understand that in this operation:

- The urethra and its orifice are placed in a position to approximate to female anatomy. Labia minora and majora are fashioned out of penile and scrotal skin.
- An innervated clitoris can be fashioned out of the glans penis if requested. However, if this option is not initially performed, it cannot be performed later.
- I understand that this is serious and extensive surgery and that there may be surgical complications requiring follow-up treatment.

Possible problems associated with surgery

- :
- The process of shortening the urethra (the tube which carries urine out of the body) sometimes causes a stricture, or healing may be asymmetric. This may result in difficulty in passing urine or may cause the urinary stream to be at an awkward angle. If the problem is sufficiently severe, further surgery may be required.
 - If infection occurs, the labia may be scarred which could mar the cosmetic result.
 - If an innervated clitoris is to be created, this could have insufficient blood supply and die, or it may not have any sensation, or it may be so sensitive as to be quite painful. If this occurs, it may have to be denervated or removed. This would seriously impair or prevent altogether the ability to achieve orgasm. It should be noted, however, that in some individuals, the painful sensations may disappear after one or even two years.
 - I understand that post-surgery I will need to continue hormone medication to retain feminisation.
 - I understand that the removal of my male sexual organs is, effectively, irreversible. Reconstructive surgery cannot fully reinstate my pre-operative condition. I will remain infertile
 - I understand that smoking increases the health risk of any surgery
 - I understand that major surgery carries risks of deep vein thrombosis, pulmonary embolism, post operative chest infections etc.
 - I am over 18 years old.
 - I have read this document and I consent to undergoing the surgery as outlined above.

Signed date

(Patient)

- I am satisfied that understands the nature of the proposed treatment and has a full understanding and appreciation of the consequences of both the treatment in terms of intended and possible side-effects and, also, the possible consequences of failure to treat.

Signed date
(Surgeon)

- I authorise the engagement on my behalf of an anaesthetist and other physicians if necessary. [I agree to take part in any anonymised follow-up surveys]

Signed date.....
(Patient)

INFORMED CONSENT for GENDER CONFIRMATION SURGERY
(may be used in conjunction with NHS or other hospital consent forms)
(Trans woman)

.....
[Print name in full]

[address]
.....
.....
.....
..... [postcode]

I agree that I have had the implications of gender confirmation surgery explained to me in full by the Surgeon,(name of Surgeon). I have had this form for at least eight (8) weeks and I have had the opportunity to discuss the effects of this surgery with my surgeon.

I understand that the capacity to reproduce will be lost, irreversibly, unless I have taken steps to store sperm, or I am intending to undergo surgical removal and storage of testes during surgery. I have been given information about these possibilities.

I identify as **female** and I understand that my gender confirmation surgery may include orchidectomy, penectomy, labiaplasty, vaginoplasty with clitoroplasty, that is, the removal of external genitalia and the creation of a vagina, clitoris and labia minora and majora. The aim of the surgery will be to create an acceptable female cosmetic appearance, a functional vagina and, possibly, to retain sexual sensation.

I understand that in this operation:

- A vagina is created by making a space between the rectum and the prostate gland, and lining this with skin from the penis and scrotum. The erectile tissue from the penis is largely removed as are the testicles; this is completely irreversible.
- The urethra and its orifice are placed in a position to approximate to female anatomy. Labia minora and majora are fashioned out of penile and scrotal skin.
- An innervated clitoris can be fashioned out of the glans penis if requested. However, if this option is not initially performed, it cannot be performed later.
- I understand that this is serious and extensive surgery and that there may be surgical complications requiring follow-up treatment.

Possible problems associated with surgery:

- Whilst creating the space between the prostate and the rectum, either the rectum or the urethra may be damaged. This could cause difficulty with control of the bladder or bowels or could lead to a fistula (communication) between the rectum and the newly created vagina. This would allow leakage of the bowel contents through the vagina. If such damage is recognised at the time of surgery, a temporary colostomy (bringing part of the bowel to the surface of the tummy) might be performed. If the complication occurred later, further surgery may be needed.
- The skin lining the new vagina is taken from the penis or scrotum, and may not have sufficient blood supply and may, therefore, become infected and die which would cause the vagina to become too small. Despite all post-operative care and precautions, the new vagina may prolapse. There is greater risk of this happening in the first three months post-operatively. Further surgery may be required to correct this.
- The pelvis, which is narrower in the male skeleton than in the female, governs the width of the newly created vagina, so that it too will be narrower.

The process of shortening the urethra (the tube which carries urine out of the body) sometimes causes a stricture, or healing may be asymmetric. This may result in difficulty in passing urine or may cause the urinary stream to be at an awkward angle. If the problem is sufficiently severe, further surgery may be required.

- If infection occurs, the labia may be scarred which could mar the cosmetic result.
- If an innervated clitoris is to be created, this could have insufficient blood supply and die, or it may not have any sensation, or it may be so sensitive as to be quite painful. If this occurs, it may have to be

denervated or removed. This would seriously impair or prevent altogether the ability to achieve orgasm. It should be noted, however, that painful sensation may disappear after one or even two years.

- I understand that post-surgery I will need to continue hormone medication but, possibly at a reduced level.
- I understand that the removal of my male sexual organs is, effectively, irreversible. Reconstructive surgery cannot fully reinstate my pre-operative condition. I will remain infertile
- I understand that smoking increases the health risk of any surgery
- I understand that major surgery carries risks of deep vein thrombosis, pulmonary embolism, post operative chest infections etc.
- I understand that dilation and douching of the vagina is essential after-care.
- I am over 18 years old.
- I have read this document and I consent to undergoing the surgery as outlined above.

Signed date
(Patient)

- I am satisfied that understands the nature of the proposed treatment and has a full understanding and appreciation of the consequences of both the treatment in terms of intended and possible side-effects and, also, the possible consequences of failure to treat.

Signed date
(Surgeon)

- I authorise the engagement on my behalf of an anaesthetist and other physicians if necessary. (I agree to take part in any anonymised follow-up surveys)

Signed date.....

INFORMED CONSENT for GENDER CONFIRMATION SURGERY

B(8)

(may be used in conjunction with NHS or other hospital consent forms)

(Trans man)

.....
[Print name in full]

[address]
.....
.....
.....
..... [postcode]

I agree that I have had the implications of gender confirmation surgery explained to me in full by the Surgeon,(name of Surgeon). I have had this form for at least eight (8) weeks and I have had the opportunity to discuss the effects of this surgery with my surgeon.

I identify as **male** and I understand that my gender confirmation surgery may include: mastectomy, hysterectomy, salpingo-oophorectomy, vaginectomy, that is, removing my internal organs of reproduction including the vagina, uterus and ovaries.

Further surgical procedures may include: metoidoplasty, scrotoplasty, urethroplasty, placement of testicular prosthesis, and phalloplasty, that is, the creation of a micropenis, scrotum, tube within the penis through which urine may be excreted, a full sized penis and/or a penis which can be made erect. (delete any that do not apply). The aim of such surgical procedures will be to create an acceptable male cosmetic appearance, to enable urination whilst standing, to provide sexual sensation and the ability to have sexual intercourse. (delete any that do not apply).

- I understand that the removal of my female sexual organs is irreversible.
- I understand that the capacity to reproduce will be irreversibly lost unless I have taken steps to store eggs or I am intending to undergo surgical removal and storage of ovaries.
- I understand that post-surgery, I will need to continue hormone medication, but at a reduced level.
- I understand that a lifelong maintenance dose of androgens (testosterone) is likely to be required, although, a reduction in the dosage of testosterone will be considered for health reasons after oophorectomy (removal of ovaries)
- I am over 18 years old.
- I understand that this is serious and extensive surgery and that there may be surgical complications requiring follow-up treatment. These have been explained to me.
- I understand that smoking increases the risk of any surgery.
- I consent to undergoing the surgery as outlined above.

Signed date
(Patient)

I am satisfied that understands the nature of the proposed treatment and has a full understanding and appreciation of the consequences of both the treatment in terms of intended and possible side-effects and, also, the possible consequences of failure to treat.

Signed date
(Surgeon)

I authorise the engagement on my behalf of an anaesthetist and other physicians if necessary. [I agree to take part in any anonymised follow-up surveys]

Signed date.....

INFORMED REFUSAL TO UNDERGO CERTAIN EXAMINATIONS

(may be used in conjunction with NHS or other hospital consent forms)

(Trans man)

.....
[Print name in full] [address]
.....
.....
..... [postcode]

I identify as male and I agree that I have had the implications of treatment with masculinising hormones explained to me in full by(name of Clinician). I have signed the form B(8a), consenting to the treatment and acknowledging the details of the effects and consequences of the treatment.

The usual physical examinations, which are undertaken prior to starting hormone therapy, have also been explained to me, as well as the reasons why my doctor considers these examinations to be important for my continuing health and well-being. I understand that these examinations may be done either by a doctor at the Gender Identity Clinic, or by my General Practitioner. I confirm that I have been offered the choice of a male or a female doctor and, in addition, a chaperone of my own choosing.

I have had this form for at least four (4) weeks and I have had the opportunity to discuss, in full, the reasons for the examinations and the possible consequences, listed below, of my refusal to undergo all or any of them. I fully understand that if I progress to surgery, the relevant examinations will have to be done, in any event.

The examinations under discussion are:

- 1. Full physical examination of the breast
- 2. Full external examination of the genitalia
- 3. Full internal examination of the vagina and cervix.

The possible consequences of refusing are:

- 1. that any possible cancer risk in the breast tissue might be overlooked. This could be life-threatening
- 2. that any cancer or pre-cancerous changes of the vagina and/or cervix would be overlooked. This could be life threatening
- 3. that any possible physical difficulties, which may contra-indicate surgery, would be missed at the early stage, and may delay such treatment, should I wish to proceed to full gender confirmation surgery at a later date. Without this examination it will not be possible for the doctor to give confirmation that I would be a suitable candidate for surgery in the future.
- 4. that any unusual physical development of the genitalia would be missed, at this stage. An early diagnosis of any such unusual development would normally result in an immediate referral to a specialist Gynaecologist so that, if necessary, some treatment could be initiated.

I fully understand:

- 1. the physical examinations that are being proposed
- 2. the reasons for those examinations, and
- 3. the possible consequences of refusing them
- 4. also, that my doctor believes it is in my best interests in terms of my health and well-being to undergo the examinations.

I have had the opportunity to consider all the points raised in this document and to query, with my doctor, any points I did not understand. I REFUSE THE FOLLOWING EXAMINATIONS: [FULL EXAMINATION OF BREASTS]

[FULL EXTERNAL EXAMINATION of GENITALIA]

[FULL INTERNAL EXAMINATION of VAGINA & CERVIX] (delete as applicable)

- Signed(Patient) date
- I am satisfied that(Patient) understands the nature of the proposed treatment and has a full understanding and appreciation of the possible consequences of refusing the physical examinations outlined above, at this stage.
- Signed(Clinician) date