**Consent Form for Hormone Therapy for Transgender Males**

**A.** The full medical effects and safety of hormone therapy are not fully known. Potential adverse effects may include, but are not limited to:

* Increased cholesterol and/or fats in the blood, which may increase risk for heart attack or stroke
* Increased number of red blood cells (increased hemoglobin), which may cause  headache, dizziness, heart attack, confusion, visual disturbances, or stroke
* Acne
* Increased risk of the following:
  + Heart disease and stroke
  + High blood pressure
  + Liver inflammation
  + Increased or decreased sex drive and sexual functioning
  + Psychiatric symptoms such as depression and suicidal feelings, anxiety, psychosis (disorganization and loss of touch with reality), and worsening of pre-existing psychiatric illnesses

**B.** Some side effects from hormones are irreversible and can cause death.

**C.** The risks for some of the above adverse events may be INCREASED by:

* Pre-existing medical conditions
* Pre-existing psychiatric condition
* Cigarette smoking
* Alcohol use

**D.** Irreversible body changes (potentially increases with length of time on hormones) resulting from hormone therapy may include, but are not limited to:

* Deepening of voice
* Development of facial & body hair
* Fat redistribution
* Genital changes (i.e. enlargement of clitoris & labia, vaginal dryness)
* Infertility
* Male pattern baldness

**E.** My signature below constitutes my acknowledgement of the following:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has discussed with me the nature and purpose of hormone therapy; the benefits and risks, including the risk that hormone therapy may not accomplish the desired objective; the possible or likely consequences of hormone therapy; and other alternative diagnostic or treatment options.

I have read and understand the above information regarding the hormone therapy, and accept the risks involved.

I have had sufficient opportunity to discuss my condition and treatment with my medical provider, and all of my questions have been answered to my satisfaction.

I believe I have adequate knowledge on which to base an informed consent to the provision of hormone therapy.

I authorize and give my informed consent to the provision of hormone therapy.

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Name of Patient (printed):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Witness (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adapted from the *Guidelines and Protocols for Comprehensive Primary Health Care of Trans Clients* by the Sherbourne Health Centre (2009)