INFORMED CONSENT FOR FEMINIZING HORMONES (like Estrogen) AND ANTI-ANDROGEN THERAPY/BLOCKERS
TRANS FEMININE SPECTRUM (MTF)

____ 1) I understand that everyone is different and the changes and risks that are listed within this consent are variable. With this therapy, I understand that feminizing hormones will be administered to me for the purpose and goal of synchronizing my secondary sexual characteristics with my gender identity.

____ 2) I have been told that the feminizing effects of estrogen can take several months to years to become noticeable and several years to be complete. Some of these changes will be **permanent** including:

- Development of breasts. This may take many years. There are natural variations in the size of breasts. One person's breast development will not correlate with that of another person's. If estrogen therapy is discontinued, there may be some decrease in breast size, but breast development will not completely disappear.
- Changes in fertility and sperm production.

___ 3) There are some additional changes will **not be permanent** and may go away if I stop taking estrogen:

- Body hair will become less noticeable and will grow more slowly. But it won't stop completely, even if I take the medicines for years.
- Less fat on my abdomen and more on my buttocks, hips, and thighs. It will be redistributed to a more female shape, changing from apple-shape to pear-shape.
- If I have male pattern baldness it may slow down, but probably will not stop completely. It is also very likely that hair that has been lost will not grow back.
- Loss of muscle and strength in my upper body.
- Skin may become softer.
- Changes to libido and sexual function
- Mood changes may happen ON estrogen and if you STOP estrogen.

____ 4) I understand that estrogen may cause or contribute to depression. If I have a history of depression I will discuss this with my provider to explore treatment/therapy options that are available.

____ 5) I understand the effects of estrogen will not protect me for sexually transmitted diseases or HIV and that condoms or barrier methods should be used.

____ 6) Due to breast development with estrogen therapy, I understand that I will need to do monthly breast self-examinations and have an annual medical exam. My provider my suggest mammograms when medically indicated.

____ 7) I understand that my Adam's apple will not shrink and that the pitch of my voice will not change

____ 8) I understand that estrogen therapy will decrease hormones that support the size and function of testicles, which may then affect sexual functioning and fertility. The changes that may occur include:

a) Decrease in overall size of penis and scrotum
b) The amount and quality of erections and ejaculation may decrease or stop entirely
c) Sperm may still be present in the testicles, but may stop maturing which may cause infertility. This may or may not affect my fertility.
d) If estrogen therapy is stopped, the ability to make healthy, mature sperm may not ever return.

____ 9) I understand that taking estrogen can significantly increase the risk of blood clots in the legs which can result in:

a) Death
b) Deep vein thrombosis (clot which forms deep in a muscle/vessel)
c) Pulmonary embolism (blood clot to the lung, which can cause permanent lung damage or death)
d) Cerebral vascular accident (stroke) which may result in permanent brain damage, blindness, paralysis, difficulty talking or death.

The risk for these events can be made worse by preexisting medical conditions such as high blood pressure, some illegal drug use, smoking and some diseases that run in families.

____ 10) ***I understand that the risk of blood clots, heart attack, and stroke on estrogen therapy is increased further if I use tobacco, especially if I am over the age of 35.*** I have been informed that my medical provider can offer me several options to support and assist me with the process of stopping smoking if so desired or needed. Although this is not required, it is HIGHLY encouraged.

____ 11) I understand the production of a hormone called prolactin increases while taking estrogen. The level of this hormone will be followed by my provider regularly. An abnormal rise in prolactin can mean the formation of kind of brain tumor and can require stopping estrogen therapy in addition to the treatment of this condition.

____ 12) I know these medicines may damage the liver and may lead to lead to liver disease. I know I should be checked for possible liver damage as long as I take them.

____ 13) I understand that the most dangerous side effects from estrogen therapy occur in connection with smoking cigarettes, being overweight, being over 35 years old, having a history of blood clots, high blood pressure, or prior estrogen related cancer. I understand that estrogen therapy may be discontinued or adjusted at any time if concerns or complications come up which are threatening to physical or mental health.

____ 14) I understand that estrogen may increase the chance of migraine headaches. This may be a reason for me to choose to stop taking estrogen, or may be a reason for estrogen to be discontinued by my provider.

____ 15) I understand that estrogen may cause changes in my cholesterol. Often this is influenced by dietary choices as well as by genetics. My clinician may recommend that we treat my high cholesterol with diet changes or medication.

____ 16) I understand that the use of some hormone blockers can cause abnormal changes to potassium blood levels which can cause abnormal heart rhythms. This will be monitored at medical appointments.

____ 17) I agree to tell my medical provider about any hormones, dietary supplements, herbs, recreational drugs or medications I might be taking. I also understand that any of the above items may be detrimental to my health and could be interact negatively with estrogen. I have been informed that clinic staff will continue to provide me with medical care, regardless of what information I share with them.

____ 18) **I agree to take estrogen and all other transition related medications as prescribed** and to inform my provider of any problems or dissatisfactions I may have in meeting my transition goals.

____ 19) I understand that I can choose to stop taking hormones and androgen blockers at any time. I also understand that my provider can discontinue treatment for clinical reasons

____ 20) I understand that taking hormones for medical transition requires regular medical visits and routine lab work. These intervals have been explained to me. Should I be unable to attend these visits hormones may be discontinued or delayed in refill. If I am not seen yearly, my hormones/blockers might not be refilled.

____ 21) I know these medicines cause changes that other people will notice. Some transgender people have experienced harassment, discrimination, and violence because of this. Others have lost the support of loved ones. I know my clinician can help me find advocacy and support resources.

____ 22) The Christ Hospital provides medical and related transition services using an informed consent model. I understand that this means the following:

a) I have been given information about the risks and benefits of estrogen and blockers.
b) I understand this information well enough to receive these services.
c) I have been provided a list of community and supplemental resources for support and further information.
d) I have had the opportunity to ask questions of my medical provider with satisfactory answers provided

____ I have read and understand the above information regarding hormone and anti androgen therapy and accept the risks involved.

____ I authorize and give my informed consent for the provision of hormone therapy as related to medical transition.

_____	_____	_____
Patient (Print)	Patient (Signature)	Date
_____	_____	_____
Guardian (Print)	Guardian (Signature)	Date
_____	_____	_____
Clinician (Print)	Clinician (Signature)	Date