INFORMED CONSENT FOR MASCULINIZING HORMONES (Like testosterone)

TRANS MASCULINE SPECTRUM (FTM)

____ 1) I understand that everyone is different and the changes and risks that are listed within this consent may not apply to everyone. With this therapy, I understand that masculinizing 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 informed that masculinizing effects of testosterone may take several months to years to become noticeable, up to five years to be complete. Some of these changes will be permanent, including:

- Hair loss, especially at my temples and crown/top of my head and, possible baldness.
- Facial hair growth
- Deepening of my voice
- Increased hair growth on my arms, legs, chest, back, and abdomen
- Enlargement of the clitoris

____ 3) The following changes will not be permanent if I stop testosterone:

- Decrease of fat in my breasts, buttocks and thighs
- Increase of fat in my abdominal region
- Increase in muscle mass/size
- More red blood cells in my blood which will be seen in my labwork
- Mood/Behavioral changes, similar to those experienced at male puberty such as aggression or irritability.
- Increased sex drive
- Increase in appetite
- Acne, which may become severe and may cause permanent scarring if not treated
- Cessation of menses/ stopping of periods

____ 4) I understand that taking testosterone may not change my risk for cervical cancer/abnormal PAP smears as long as I still have a cervix. My provider has discussed with me the needed screening exams and timeframe for them. I may also need mammograms, this too will be discussed with my clinician.

____ 5) I understand that it is not known or exactly understood what the effects of testosterone are on fertility. I have been informed that, if I stop taking testosterone, I may not be able to become pregnant.

____ 6) I understand that although unlikely, it is possible for me to become pregnant while taking testosterone and additional methods of birth control have been discussed if this applies to me.

____ 7) I understand that dose of testosterone may vary from person to person and that my dose of testosterone may be different from that another person.

___ 8) 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 being refilled.

___ 9) I understand that I will need to be **seen at least yearly by my primary care doctor**, to continue to have testosterone prescribed for me. If I am not seen yearly, my refills for testosterone can be denied.

____ 10) I understand that testosterone can increase my risk for developing diabetes, high blood pressure and contribute to obesity. Having pre existing conditions or a family history of these may further increase my risk.

____ 11) I understand that through normal action in the blood, taking testosterone can increase the level of the estrogen in my body. My clinician will monitor and inform me of needed changes to my dose should this occur.

____ 12) 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 testosterone. I have been informed that clinic staff will continue to provide me with medical care, regardless of what information I share with them.

____ 13) I agree to take testosterone 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. I know that taking more than I am prescribed won't make changes happen more quickly or more significantly. I know my body can convert extra testosterone into estrogen, and that can slow down or stop my appearing manlier.

____ 14) I understand that I can choose to stop taking testosterone at any time. I also understand that my provider can discontinue treatment if medically necessary.

____ 15) I know that testosterone causes 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.

____ 16) 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 testosterone
b) I understand them well enough to give informed consent for 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 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 (Signature)	Patient (Print)	Date
_____	_____	_____
Guardian (Signature)	Guardian (Print)	Date
_____	_____	_____
Clinician (Signature)	Clinician (Print)	Date