



Consent for Estrogen-Based Hormone Therapy

The informed consent model of care respects your fundamental human right to self determination and bodily autonomy. This document indicates you consent to hormone therapy as part of a gender affirmation process.

- Hormone therapy is not FDA approved and there is little research on its long term effects.
- Hormone therapy affects everyone differently. It may take months to years for effects to evolve and there is no way to predict its changes for me.
- The following changes are expected with testosterone therapy:

Likely permanent changes: Breasts growth Decreased testicle size	Likely reversible changes: Decreased muscle mass and strength Body fat redistribution Softening of skin Decreased sex drive and sexual function Thinning/slow growing of hair
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- The following are potential side effects and risks of hormone therapy.

Likely risks: Breast tenderness Fluid retention, bloating Mood changes (teariness) Headaches Nausea	Possible risk: Infertility Blood clots Cardiovascular disease Breast and prostate cancer Liver disease including gallstones Prolactinoma (a rare brain tumor) Diabetes
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- Estrogen is not a birth control method and unintended pregnancy is still possible. Contraception should be used when having sex that puts me at risk.
- Monitoring hormone therapy will require regular office visits to ensure appropriate dosing and confirm I am moving towards my goals in therapy. These will be more frequent at first.
- A healthy lifestyle like balanced diet, regular exercise, and maintaining a healthy weight may reduce some associated risks. Smoking any nicotine product while on estrogen increases my risk of potentially fatal blood clots.
- Routine health screenings are recommended to detect and prevent health conditions.
- Continuing hormone therapy requires ongoing monitoring of my health. I am responsible for informing us of all your medications and medical conditions now and going forward.

Your signature below confirms that you have reviewed and understand the information in this document, feel that all your questions have been answered, have adequate information to make a decision, and that you feel that hormone therapy is appropriate and necessary for you.

Signature: _____ Date: _____

Provider signature: _____ Date: _____