



## Consent for Testosterone-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:**

Voice deepening  
 Enlarged clitoris  
 Hair growth

**Likely reversible changes:**

Increased muscle mass and strength  
 Body fat redistribution  
 Increased sex drive  
 Periods and ovulation stop  
 Vaginal dryness  
 Mood changes  
 Acne

- The following are potential side effects and risks of hormone therapy.

**Likely risks:**

Acne  
 Weight gain  
 Polycythemia (increased red blood cells)  
 Baldness  
 New or worsening sleep apnea

**Possible risk:**

Liver disease  
 Uterine, endometrial and breast cancers  
 Worsening of mental health problems  
 Cardiovascular disease  
 Diabetes  
 Infertility  
 Osteoporosis

- Testosterone is not a birth control method and unintended pregnancy is still possible. Contraception should be used when having sex that puts me at risk of pregnancy as testosterone can cause serious birth defects.
- 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 lack of smoking may reduce some associated risks.
- Routine health screenings are recommended to detect and prevent health conditions. This may include breast and cervical cancer screenings.
- 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: \_\_\_\_\_