

SPECIFIC INFORMED CONSENT FOR HORMONE THERAPY FOR  
MEN OF TRANSGENDER EXPERIENCE (UNDER 18 YEARS OLD)



Medical Record No: \_\_\_\_\_

## Consent Form

PATIENT NAME: \_\_\_\_\_

BIRTH OF DATE: \_\_\_\_\_

### Initiation of Care

Hormone therapy is an important component of transition for some transgender clients, changing secondary sex characteristics to affirm a gender presentation that is consistent with their gender identity. While there are risks associated with taking feminizing/masculinizing medications, when appropriately prescribed they can greatly improve quality of life and psychological well-being. The goal of this consent form is to review the potential risks and benefits associated with use of hormone therapy.

**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 or decreased cholesterol and/or fats in the blood, which may increase risk for heart attack or stroke**
- **Blood clots, (deep venous thrombosis, pulmonary embolism);**
- **Heart disease, arrhythmias, and stroke;**
- **High blood pressure**
- **Liver inflammation**
- **Decreased number of red blood cells (anemia)**
- **Acne**
- **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 condition
- Pre-existing psychiatric conditions
- Cigarette smoking
- Alcohol use

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

- Increased bone density
- Fat redistribution
- Genital changes (i.e., enlarged clitoris and/or labia)
- Infertility
- Male pattern baldness

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

- My medical provider 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 all feasible alternative diagnostic or treatment options
- I have read and understand the above information regarding the hormone therapy, and accept the risks involved
- I have met with a provider for education and support regarding hormone therapy
- I have received a list of community services and resources for people of transgender experience
- I have had sufficient opportunity to discuss my condition and treatment with the medical provider, nursing staff, and/or other staff, 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 Client:**

**Date:**

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**Legal Name of the Client (Printed):**

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**Signature of Parent/Guardian:**

**Date:**

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**Name of Parent/Guardian (Printed):**

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**Medical Provider's Name:**