APPENDIX D:

preventative care checklist for transfeminine patients

For annual health assessments of transfeminine patients, applying to patients who were assigned male at birth and have a gender identity that is female or on the feminine spectrum, who may or may not have accessed hormonal and/or surgical treatments for gender dysphoria/gender incongruence.

Prepared by: Dr. A. Bourns · Adapted from the Preventive Care Checklist Form © 2016

(see Ridley, J, Ischayek, A., Dubey, V., Iglar, K., *Adult health Checkup: Update on the Preventive Care Checklist Form*© Canadian Family Physician, 2016 Apr; 62:307-313)

Please note: **Bold** = transgender-specific considerations, see Explanation Sheet for detailed recommendations

Unbolded items should be followed according to the most recent update to the original Preventive Care Checklist©

IDENTIFYING DATA:

Name:____________________

Tel:____________________

DOB:____________________

Age:____________________

Date of Examination:____________________

MEDICAL TRANSITION HISTORY:

Androgen Blocker:

☐ Spironolactone ☐ Cyproterone ☐ N/A

Estrogen: ○ Yes ○ No

If Yes, Start Date:____________________

Orchiectomy: ○ Yes ○ No

Vaginoplasty: ○ Yes ○ No

Breast Aug: ○ Yes ○ No

CURRENT CONCERNS

LIFESTYLE/HABITS/PSYCHOSOCIAL:

Diet:____________________

Fat/Cholesterol____________________

Fiber____________________

Calcium ____________________

Sodium____________________

Exercise:____________________

Work/Education:____________________

Poverty:____________________

Social supports:____________________

Family:____________________

Relationships:____________________

Sexual History:____________________

Family Planning/Contraception:____________________

Name change/identification:____________________

Sleep:____________________

Smoking:____________________

Alcohol:____________________

Safe Guidelines ≤10/week, ≤2/day

Drugs:____________________

MENTAL HEALTH

Screen for:

Depression	○ Positive	○ Negative
Suicidal Ideation	○ Positive	○ Negative
Self-harm	○ Positive	○ Negative
Anxiety	○ Positive	○ Negative
Persistent Gender Dysphoria	○ Positive	○ Negative
Experiences/Impacts of transphobia	○ Positive	○ Negative

UPDATE CUMULATIVE PATIENT PROFILE

- ☐ Family History
- ☐ Medications
- ☐ Hospitalizations/Surgeries
- ☐ Allergies

FUNCTIONAL INQUIRY

	Normal	Remarks:
HEENT:	☐	________
CVS:	☐	________
Resp:	☐	________
Breasts:	☐	________
GI:	☐	________
GU:	☐	________
Sexual Function:	☐	________
MSK:	☐	________
Neuro:	☐	________
Derm:	☐	________
Constitutional Sx:	☐	________

PHYSICAL EXAMINATION:

Physical examination, as required, taking into consideration pre-existing conditions and presenting complaints

BP ________ HT ________

WT ________ BMI ________

☐ Or See EMR Vitals

May include:

Breasts ________

Tanner stage ________

Breast circumference ________

Areolar diametre ________

Genitourinary ________

Ano-rectum ________

EDUCATION/COUNSELLING

Behavioural

- ☐ adverse nutritional habits
- ☐ dietary advice on fat/choleseterol
- ☐ **adequate calcium intake (1200 mg daily diet + supp)**
- ☐ **adequate vitamin D (1000 IU daily**)
- ☐ **hormone adherence**
- ☐ **regular, moderate physical activity**
- ☐ avoid sun exposure, use protective clothing
- ☐ **safe sex practices/STI counselling/PrEP indications**

Overweight (BMI 25-29) or Obese (BMI 30-39)

- ☐ Overweight (BMI 25-29)
- ☐ Obese (BMI 30-39)
  - ☐ structured behavioural interventions for weight loss
  - ☐ **screen for mental health contributors**
  - ☐ multidisciplinary approach

Underweight

- ☐ **Underweight (BMI<18)**
  - ☐ screen for eating disorders

Smoking

- ☐ smoking cessation
- ☐ nicotine replacement therapy/other medications
- ☐ dietary advice on fruits and green leafy vegetables
- ☐ referral to validated smoking cessation program

Alcohol & other substances

- ☐ case finding for problematic substance use
- ☐ counselling for problematic substance use
- ☐ **referral for substance abuse treatment**
- ☐ **provide naloxone kit if indicated**

Elderly

- ☐ cognitive assessment (if concerns)
- ☐ fall assessment (if history of falls)
- ☐ **advanced care planning**

Oral hygeine

- ☐ brushing/flossing teeth
- ☐ fluoride (toothpaste/supplement)
- ☐ tooth scaling and prophylaxis
- ☐ smoking cessation

Personal safety

- ☐ hearing protection
- ☐ noise control programs
- ☐ seat belts
- ☐ **injection safety**
- ☐ **bathroom safety**

Parents with children

- ☐ poison control prevention
- ☐ smoke detectors
- ☐ non-flammable sleepwear
- ☐ hot water thermostat settings (<54°C)

LABS / INVESTIGATIONS

≤64 YEARS	≥65 YEARS
☐ **Mammogram (estrogen ≥5 years total and avg risk: age 50-64 q2 yrs)**	☐ **Mammogram (estrogen ≥5 years total and avg risk age: 65-74 q2 yrs**
☐ Fecal immunochemical test (FIT) (age 50-64 q2 yrs) OR ☐ Sigmoidoscopy OR ☐ Colonoscopy	☐ Fecal immunochemical test (FIT) (up to 74 yrs q2 yrs) OR ☐ Sigmoidoscopy OR ☐ Colonoscopy
☐ **GC/CT/Syphilis/HIV/HBV/HCV screen (high risk**)	☐ **GC/CT/Syphilis/HIV/HBV/HCV screen (high risk**)
☐ **Bone Mineral Density if at risk**	☐ Bone Mineral Density
	☐ Audioscope (or inquire/whispered voice test)

Consider Anal Pap if history of receptive anal sex, q2-3 yrs or yearly if HIV+ (age range not defined)

ANNUAL TRANS BLOODWORK (ALL AGES, ASSUMING 12 MONTHS ON HORMONE THERAPY)

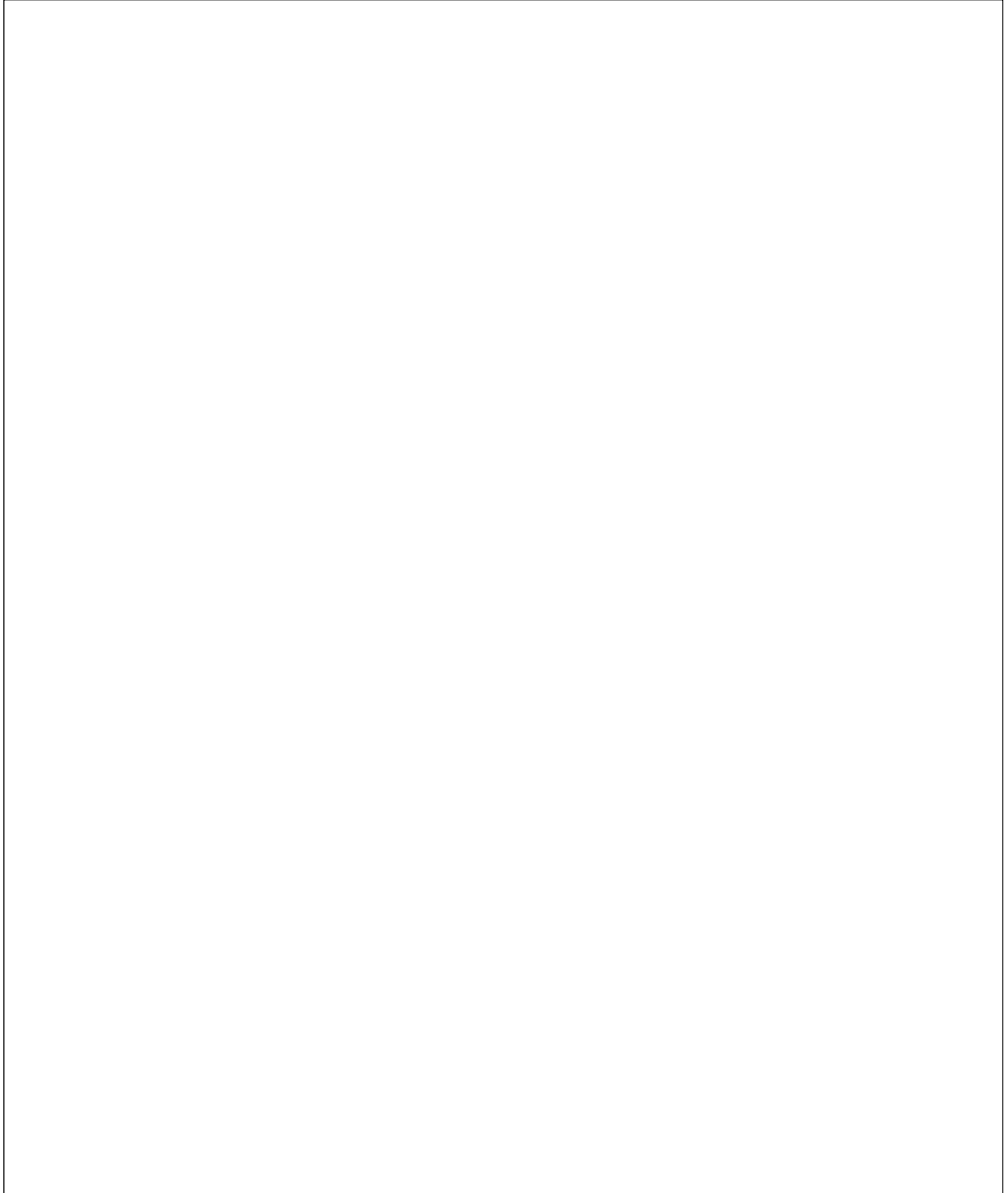
Lab Test	Indication
☐ CBC*	on cypro or first year on hormone therapy
☐ Cr, lytes**	on spiro or first year on cypro
☐ ALT+/-AST	on estrogen or cypro
☐ Lipid Profile	at 12 mos, then per routine guidelines
☐ Hba1c or FPG	at 12 mos, then per routine guidelines
☐ Estradiol	on estrogen
☐ Prolactin	on cypro
☐ Total testosterone	on antiandrogen

*Hb/Hct - use female reference for LLN and male reference for ULN
**Cr - use male reference range for ULN

IMMUNIZATIONS

≤64 YEARS	≥65 YEARS
☐ Tetanus vaccine q10 yrs	☐ Tetanus vaccine q10 yrs
☐ Influenza vaccine q1 yr	☐ Influenza vaccine q1 yr
☐ Acellular pertussis vaccine	☐ Pneumococcal vaccine
☐ Varicella vaccine (2 doses)	☐ Acellular pertussis vaccine
☐ **Human papillomavirus vaccine (consider up to age 45 yrs, publicly covered ≤26 yrs if sexually active with MSM)**	☐ Varicella vaccine (2 doses))
☐ Measles/mumps/rubella vaccine	☐ Herpes zoster vaccine (publicly covered 65-70yrs)
☐ Meningococcal vaccine	
☐ Herpes zoster vaccine (consider ≥60 yrs)	
☐ **Hepatitis A/Hepatitis B** ☐ **Hep A immunity** ☐ **Hep B immunity**	

ASSESSMENT AND PLANS



APPENDIX E:
accompaniment to the preventive care checklist for transfeminine patients

EXPLANATIONS FOR TRANS-SPECIFIC RECOMMENDATIONS

Note: This form has been adapted with permission from Dr. V. Dubey from the CFPC-endorsed Preventive Care Checklist Form©. The use of these trans-specific forms assumes familiarity with the original forms and their explanations. The original form contains graded evidence-based recommendations,[1] which may or may not be applicable to transgender patients. Unbolded recommendations should be followed as per the original forms. The specific recommendations herein represent an effort to incorporate expert opinion and limited trans-specific evidence with standard National and Provincial primary care practices in a practical format that can be accessed at the point-of-care.

MEDICAL TRANSITION HISTORY

Establishment of a patient's status regarding gender-related treatments and timing of these treatments at the outset of a preventive care assessment allows for patient-centred tailoring of counselling, education, physical examination, and screening recommendations.

LIFESTYLE/HABITS/PSYCHOSOCIAL

An effort should be made to assess the impact of transition/trans identity, experiences of transphobia and impact on employment, housing, family, relationships, and economic well-being.

Social Supports – specific attention should be given to assessing the extent of a patient's social supports, creating an opportunity to suggest additional resources if needed.

Sexual History – delineating the types of sex that a patient is having and with whom will direct the indicated type and frequency of STI screening.

Family Planning/Contraception – transfeminine patients planning to undergo hormonal treatment and/or gonadectomy should be counselled regarding the option for fertility preservation, those who have not undergone gonadectomy and are on hormonal therapy should be counselled regarding the variable effect on fertility and the need for contraception if sexually active with a partner who may become pregnant. (See *Guidelines for gender-affirming primary care with trans and on-binary patients, Part 1*, and *RHO's Reproductive Options Fact Sheet*[2] and the LGBTQ Parenting Network's 'Fertility Preservation for People Who Produce Sperm'[3])

Name change/identification – assess patient need/desire to change name and/or sex marker on identification and offer support for this process (see *Guidelines for gender-affirming primary care with trans and non-binary patients, Part I*, and *Appendices P and Q*)

Alcohol – estrogen affects the metabolism of alcohol by the liver and has been associated with elevation in liver enzymes, thus we suggest using the same safe-drinking guidelines for transfeminine individuals as for cis women (i.e. max 10 drinks a week with no more than 2 drinks a day most days, see Canada's Low-risk Alcohol Drinking Guidelines).[4]

FUNCTIONAL INQUIRY

An effort should be made to use language consistent with a patient's gender identity; if unsure - consider asking the patient how they refer to their gendered body parts.

Mental Health – inquire re: experiences/ impacts of transphobia; screen for depressive symptoms, anxiety (particularly social anxiety), and self-harm; suicidal ideation and attempts are particularly high in the trans population[5] and should be specifically inquired about; inquire re: current level of gender dysphoria and body image, (re-)assess patient interest in transition-related surgeries if not undergone.

Breasts – inquire re: breast pain (can be normal in early phases of feminization), and nipple discharge (bilateral/non-bloody discharge can be considered normal in early phases, otherwise may be indicative of hyperprolactinemia or local breast disease); if implants present consider inquiry re: symptoms of capsular contracture or rupture (pain, loss of contour, deflation).

GU – inquiry re: urinary symptoms is relevant regardless of genital operative status: spironolactone can cause urinary frequency; the prostate remains post-vaginoplasty; vaginoplasty may lead to urinary complications including increased frequency of UTIs, stricture, fistula; if post-op vaginoplasty; inquire re: vaginal discharge, pruritus, pelvic pain. Odour/discharge is most frequently due to sebum, dead skin, or keratin debris (skin graft) – routine douching with soapy water is usually adequate to maintain hygiene. Imbalances in neovaginal flora may also occur – cleansing/douching with a solution of 25% povidine iodine in water for 2-3 days may be helpful and if symptoms persist; a 5-day course of vaginal metronidazole is reasonable;[6] STIs, granulation tissue, and other neovaginal lesions should also be considered in the differential.

Sexual Function – if patient has not undergone vaginoplasty, inquire re: erectile dysfunction and if present, whether this is of concern for the patient (PDE-5 inhibitors may be considered in patients wishing to maintain erectile function); if the patient has undergone vaginoplasty, inquire re: problems with dilation, dyspareunia, post-coital bleeding, and ability to achieve orgasm (also see *Guidelines for gender-affirming primary care with trans and non-binary patients, Part II: Sexual Function and Fatigue*).

Constitutional Symptoms – fatigue in the absence of other associated symptoms suggesting another cause may be due to testosterone levels below the physiologic female range (also see *Guidelines for gender-affirming primary care with trans and non-binary patients, Part II: Sexual Function and Fatigue*).

EDUCATION/COUNSELLING

Review S/Sx DVT/PE/Stroke – consider periodic review of the signs and symptoms of DVT, PE, and stroke for transfeminine patients on hormone therapy who have additional risk factors.

Adequate Calcium Intake – all transfeminine patients on hormone therapy should ensure a minimum intake of 1200 mg of Calcium daily (total: diet + supplements).

Adequate Vitamin D – all transfeminine patients on feminizing hormone therapy should take 1000 IU of vitamin D daily.

Hormone Adherence – poor hormone adherence may impact bone health if post-orchiectomy, while extra doses may lead to risks associated with high serum levels of estrogen.

Regular, moderate physical activity – some transfeminine individuals may tend to avoid exercise for fear of unwanted muscle development; encourage aerobic exercise as well as high-repetition weight-bearing exercise for osteoporosis prevention.

Safe sex practices/STI counselling - transfeminine patients may be at high risk of STIs depending

on behavioural factors; inquire re: sexual practices and risks including sex work; safer sex counselling, frequent screening (i.e. every 3 months) and an assessment of indications for HIV PrEP[7] are indicated for those at high risk. For patient-centred handout materials, see *Brazen 2.0: Trans women's Safer Sex Guide*.[8]

Overweight/Obese – obesity may increase the thromboembolic and metabolic risks associated with estrogen therapy, weight loss counselling should be emphasized; screen for eating disorders (more prevalent in LGBT2SQ populations, particularly amongst youth).

Underweight - screen for disordered eating – persistent gender dysphoria/incongruence may be associated with a desire to maintain a thinner body habitus in order to hide indicators of natal sex, which may have negative health impacts; strategizing around other ways to address persistent gender dysphoria/incongruence may be helpful.

Smoking – smoking greatly increases the thromboembolic risks associated with estrogen therapy, smoking cessation should be emphasized.

Alcohol and other substances – substance use is more prevalent in members of the LGBT2SQ community; inquire re: problematic use of substances including hormones without a prescription; if referral to a substance abuse program is indicated, consider an LGBT2SQ-specific or LGBT2SQ-positive program such as Rainbow Services at CAMH. Offer safer smoking and injection kits when indicated for harm reduction. A naloxone kit and instructions on use should be offered to all patients who are at risk of opioid overdose, as well as friends and family of those at risk.[9]

Advanced care planning – A discussion regarding advanced care planning is recommended at least once for Canadians ≥65.[10] Trans and gender diverse patients may have particular needs in ensuring that their gender identity and expression are respected and a respectful decision-maker is chosen (See '*Creating End of Life Documents for Trans Individuals: An Advocate's Guide*').[11]

Injection safety – for patients who self-inject estrogen: confirm dose, review aseptic injection technique, inquire re: rotating injections sites, injection site reactions, and pre-injection anxiety; consider review of route options (IM vs. SC injectable, oral, transdermal), ensure safe sharps disposal; counsel re: risks of injecting non-medical silicone (i.e. 'pumping' to enhance body shape) including chronic inflammation, disfigurement, pulmonary complications, sepsis, and death.

Bathroom safety - finding a bathroom that feels comfortable and safe can frequently be a source of stress for trans individuals. Resources such as *Refuge Restrooms*[12]can assist trans people in locating gender neutral bathrooms. For those who may be experiencing urinary frequency due to spironolactone, timing of administration can be adjusted if safe bathroom access is a concern.

PHYSICAL EXAMINATION

Breasts – Evidence to date suggests that the risk of breast cancer in transfeminine individuals is not higher than in cis women and may potentially be lower than in cis women, however both benign and malignant breast disease can occur in transfeminine patients on hormone therapy (also see *Guidelines for gender-affirming primary care with trans and non-binary patients, Part II: Breast Cancer*); annual routine clinical breast exams in transfeminine patients with or without implants are of questionable utility but may be useful to assess the degree of breast development or to detect implant complications respectively. Transfeminine patients should receive counselling around breast self-awareness as is recommended for cis women.

For those who may have interest in MOHLTC-covered breast augmentation surgery, **breast inspection** at baseline and 12 months following hormone initiation is recommended, with particular attention to Tanner stage. **Measurements** such

as chest circumference at the fullest part of the breast and nipple-areolar diametre may be helpful in determining the presence or absence of breast growth, or may be of interest to some patients (see *Guidelines for gender-affirming primary care with trans and non-binary patients, Part I: Physical Exam and Baseline Investigations*).

Genitourinary – In patients who have not undergone orchiectomy, testicular examination may reveal testicular atrophy in the setting of feminizing therapy but is not routinely needed. For those who have undergone vaginoplasty, we do suggest annual (starting 1 year post-op) neovaginal speculum examination to detect any abnormalities such as granulation tissue (which may be treated with silver nitrate), active hair follicles (which may be tweezed or if extensive, cauterized under local anesthetic), warts, abnormal discharge, or malignancy; vault smears are not generally recommended as their utility in detecting dysplasia or metaplasia in keratinized epithelium is not established; neovaginal tissue created from colon can be screened for malignancy by direct visual inspection; in the extremely rare case that a neo-cervix has been surgically created, Pap guidelines may be followed as for cis women; if examination of the prostate is indicated, the prostate may be palpated along the anterior wall of the neovagina by digital examination in the lithotomy position.

Ano-rectum – for those who engage in receptive anal sex, visual examination of the perianal region for any evidence of anal warts or other anorectal problems such as hemorrhoids should be considered–particularly those who are HIV+. Additionally consider DRE for detection of internal lesions. HIV+ patients with physical findings consistent with warts or other HPV-related changes should also be referred for HRA.

LABS/INVESTIGATIONS

Mammography – consider mammography in transfeminine patients on hormone therapy every 2 years if aged 50-74 AND on estrogen for ≥5 years total (i.e. years do not need to be consecutive), consider initiating screening at a younger age if additional risk factors are present (i.e. estrogen + progestin for > 5 yrs, family history), consider obtaining expert opinion regarding the need for annual mammography with MRI for those aged 30-69 with family history suggestive of hereditary breast cancer; the presence of breast implants necessitates diagnostic mammography rather than routine screening mammography; additional imaging modalities (ultrasound, MRI) may be recommended by implant manufacturers or a patient's surgeon at regular intervals to detect silent rupture of silicone implants. GRS Montreal currently recommends annual ultrasounds from the 5th year onward to screen for silent rupture in silicone implants, while suggesting clinical exam only (without imaging) for monitoring of saline implants given that rupture causes visible deflation.

GC/CT/Syphilis/HIV/HBV/HCV screen – consider STI detection from the following sites as indicated: throat, urethra, neovagina, anorectum, and serum.

Yearly trans bloodwork – bloodwork should be tailored to the patient's hormone regimen, risk factors and pre-existing conditions; screening for DMII and dyslipidemia should be performed at baseline and 1 year following hormone therapy initiation, and otherwise according to routine guidelines for cis patients; Framingham calculation will be less reliable with exogenous hormone use - depending on the age of hormone initiation and duration of hormone exposure providers may choose to use the risk calculator for sex assigned at birth, affirmed gender, or an average of both;[6] for management of elevated prolactin levels see *Part II 'Hyperprolactinemia/Prolactinoma'*.

Note: For patients on anti-androgen +/- estrogen:

- Hb/Hct - use the female reference for lower limit of normal and male reference for upper limit of normal
- Cr - use male reference range for upper limit of normal

BMD screening – exogenous estrogens appear to effectively maintain bone mass in transfeminine patients although they may have lower BMD than age-matched cis-men at baseline. In accordance with national recommendations, perform bone mineral density testing in all transfeminine patients over age 65. BMD should be considered earlier in those at high risk, such as those who, for a significant period of time (i.e. >2 yrs):

- have been on low-dose or no hormones and are agonadal
- have been on anti-androgens without the co-administration of exogenous estrogen
- have been on a GnRH analogue without exogenous estrogen (See '*Part III: Osteoporosis and BMD Screening*')

Note: frequency of follow-up BMD screening will depend on the results of the initial scan.

Anal Pap screening – for those who have a history of receptive anal sex, consider anal pap every 2-3 years or yearly in those who are HIV+ (if local HRA for the follow up of abnormal results is available). See the Canadian Cancer Society's Colon cancer screening guidelines for gay and bisexual men for more information.

IMMUNIZATIONS

Hepatitis A/Hepatitis B – transfeminine patients may be at higher risk of Hepatitis A/B depending on behavioural risks, if behavioural risk factors are present, the patient may qualify for publicly funded vaccination similarly to MSM.

HPV – consider HPV vaccination x 3 doses in transfeminine patients up to the age of 45, tailor to risk; vaccination can be publicly covered in Ontario via the catch-up program for adolescents up to grade 12 and ≤26 years old for those who are sexually active with MSM.

CFPC – College of Family Physicians of Canada,
STI - sexually transmitted infection,
RHO – Rainbow Health Ontario,
GU - genitourinary,
UTI – urinary tract infection,
PDE-5 – phosphodiesterase-5,
DVT – deep vein thrombosis, PE – pulmonary embolus,
IU – international units,
HIV - human immunodeficiency virus,
LGBT2SQ - lesbian, gay, bisexual, trans, queer, and 2 spirit,
CAMH – Centre for Addiction and Mental Health,
IM - intramuscular,
SC - subcutaneous,
MRI- magnetic resonance imaging,
DRE - digital rectal exam,
HRA - high resolution anoscopy,
GC – gonococcus,
CT – chlamydia trachomatis,
HBV – hepatitis B virus,
HCV - Hepatitis C virus,
DMII - Diabetes mellitus type II,
Hb - hemoglobin,
Hct - hematocrit,
Cr - creatinine,
BMD – bone mineral density,
HPV – human papillomavirus,
MSM - men who have sex with men

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12. REFUGE Restrooms [Internet]. REFUGE Restrooms; [updated 2019] [cited 2019 Feb 7]. Available from: https://www.refugerestrooms.org/about

APPENDIX F:
preventive care checklist for transmasculine patients

For annual health assessments of transmasculine patients, applying to patients who were assigned female at birth and have a gender identity that is male or on the masculine spectrum, who may or may not have accessed hormonal and/or surgical treatments for gender dysphoria/ gender incongruence.

Prepared by: Dr. A. Bourns · Adapted from the Preventive Care Checklist Form © 2016

(see Ridley, J, Ischayek, A., Dubey, V., Iglar, K., Adult health Checkup: Update on the Preventive Care Checklist Form© Canadian Family Physician, 2016 Apr; 62:307-313)

Please note: **Bold** = transgender-specific considerations, see Explanation Sheet for detailed recommendations

Unbolded items should be followed according to the most recent update to the original Preventive Care Checklist©

IDENTIFYING DATA:

Name:______________________

Tel:______________________

DOB:______________________

Age:______________________

Date of Examination:______________________

MEDICAL TRANSITION HISTORY:

Testosterone: ○ Yes ○ No

If Yes, Start Date:______________________

Chest Reconstruction: ○ Yes ○ No

TAH: ○ Yes ○ No

BSO: ○ Yes ○ No

Genital Reconstruction

Clitoral Release: ○ Yes ○ No

Meta: ○ Yes ○ No

Phallo: ○ Yes ○ No

CURRENT CONCERNS

LIFESTYLE/HABITS/PSYCHOSOCIAL:

Diet:______________________

- Fat/Cholesterol______________________
- Fibre______________________
- **Calcium**______________________
- Sodium______________________
- Exercise:______________________

Work/Education:______________________

Poverty:______________________

Social supports:______________________

- Family:______________________
- Relationships:______________________

Sexual History:______________________

Family Planning/Contraception:______________________

Name change/identification:______________________

Sleep:______________________

Smoking:______________________

Alcohol:______________________

Safe Guidelines ≤10/week, ≤2/day

Drugs:______________________

MENTAL HEALTH

Screen for:

Depression	○ Positive	○ Negative
Suicidal Ideation	○ Positive	○ Negative
Self-harm	○ Positive	○ Negative
Anxiety	○ Positive	○ Negative
Persistent Gender Dysphoria	○ Positive	○ Negative
Experiences/Impacts of transphobia	○ Positive	○ Negative

UPDATE CUMULATIVE PATIENT PROFILE

- ☐ Family History
- ☐ Medications
- ☐ Hospitalizations/Surgeries
- ☐ Allergies

FUNCTIONAL INQUIRY

	Normal	Remarks:
HEENT:	☐	______
CVS:	☐	______
Resp:	☐	______
Chest:	☐	______
GI:	☐	______
GU/PV bleeding:	☐	______
Sexual Function:	☐	______
MSK:	☐	______
Neuro:	☐	______
Derm:	☐	______
Constitutional Sx:	☐	______

PHYSICAL EXAMINATION:

Physical examination, as required, taking into consideration pre-existing conditions and presenting complaints

BP ______ HT ______

WT ______ BMI ______

- ☐ Or See EMR Vitals

May include:

Chest ______

Pelvic/pap ______

Ano-rectum ______

Derm ______

EDUCATION/COUNSELLING

Behavioural

- ☐ adverse nutritional habits
- ☐ dietary advice on fat/choleseterol
- ☐ **adequate calcium intake (1200 mg daily diet + supp**)
- ☐ **adequate vitamin D (1000 IU daily)**
- ☐ **hormone adherence**
- ☐ **regular, moderate physical activity**
- ☐ avoid sun exposure, use protective clothing
- ☐ **safe sex practices/STI counselling/PrEP indications**
- ☐ **review potential for pregnancy/ assess need for birth control**
- ☐ **assess need for folic acid** (0.4-0.8 mg)

Overweight (BMI 25-29) or Obese (BMI 30-39)

- ☐ Overweight (BMI 25-29)
- ☐ Obese (BMI 30-39)
  - ☐ structured behavioural interventions for weight loss
  - ☐ **screen for mental health contributors**
  - ☐ multidisciplinary approach

Underweight

- ☐ **Underweight (BMI<18**)
  - ☐ **screen for eating disorders**

Smoking

- ☐ smoking cessation
- ☐ nicotine replacement therapy/other medications
- ☐ dietary advice on fruits and green leafy vegetables
- ☐ referral to validated smoking cessation program

Alcohol & other substances

- ☐ case finding for problematic substance use
- ☐ counselling for problematic substance use
- ☐ **referral for substance abuse treatment**
- ☐ **provide naloxone kit if indicated**

Elderly

- ☐ cognitive assessment (if concerns)
- ☐ fall assessment (if history of falls)
- ☐ **advanced care planning**

Oral hygeine

- ☐ brushing/flossing teeth
- ☐ fluoride (toothpaste/supplement)
- ☐ tooth scaling and prophylaxis
- ☐ smoking cessation

Personal safety

- ☐ hearing protection
- ☐ noise control programs
- ☐ seat belts
- ☐ **injection safety**
- ☐ **bathroom safety**

Parents with children

- ☐ poison control prevention
- ☐ smoke detectors
- ☐ non-flammable sleepwear
- ☐ hot water thermostat settings (<54°C)

LABS / INVESTIGATIONS	≤64 YEARS	≥65 YEARS
	☐ Mammography (q2 yrs age 50-74 if no chest reconstruction)	☐ Mammography (q2 yrs age 50-74 if no chest reconstruction)
	☐ **Cervical cytology** (q3 yrs if ever sexually active and 21-69 yrs)	☐ **Cervical cytology** (q3 yrs if ever sexually active and up to 69 yrs)
	☐ Fecal immunochemical test (FIT) (age 50-64 q2 yrs) OR ☐ Sigmoidoscopy OR ☐ Colonoscopy	☐ Fecal immunochemical test (FIT) (up to 74 yrs q2 yrs) OR ☐ Sigmoidoscopy OR ☐ Colonoscopy
	☐ **GC/CT/Syphilis/HIV/HBV/HCV screen (high risk)**	☐ **GC/CT/Syphilis/HIV/HBV/HCV screen (high risk)**
	☐ **Bone Mineral Density if at risk**	☐ Bone Mineral Density
		☐ Audioscope (or inquire/whispered voice test)
	Consider Anal Pap if history of receptive anal sex, q2-3 yrs or yearly if HIV+ (age range not defined)	

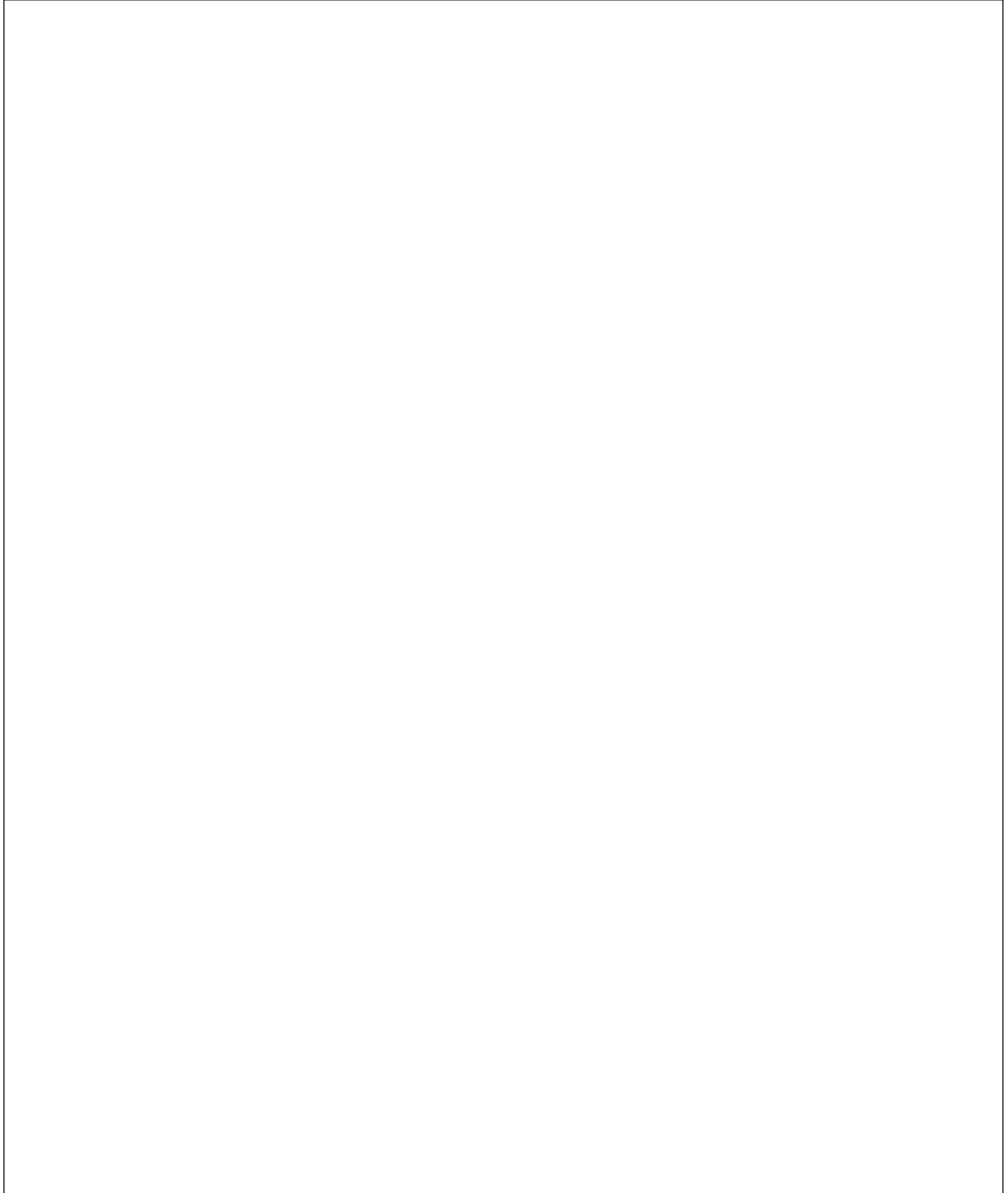
ANNUAL TRANS BLOODWORK (ALL AGES, ASSUMING 12 MONTHS ON HORMONE THERAPY)

Lab Test	Indication
☐ CBC*	yearly
☐ ALT+/-AST	per provider discretion
☐ Total testosterone	yearly
☐ LH	yearly if agonadal
☐ Lipid Profile	at 12 mos, then per routine guidelines
☐ Hba1c or FPG	at 12 mos, then per routine guidelines

*use male reference range for ULN Hb/Hct

IMMUNIZATIONS	≤64 YEARS	≥65 YEARS
	☐ Tetanus vaccine q10 yrs	☐ Tetanus vaccine q10 yrs
	☐ Influenza vaccine q1 yr	☐ Influenza vaccine q1 yr
	☐ Acellular pertussis vaccine	☐ Pneumococcal vaccine
	☐ Varicella vaccine (2 doses)	☐ Acellular pertussis vaccine
	☐ **Human papillomavirus vaccine (consider up to age 45 yrs, publicly covered** ≤26 yrs if sexually active with MSM)	☐ Varicella vaccine (2 doses)
	☐ Measles/mumps/rubella vaccine	☐ Herpes zoster vaccine (publicly covered 65-70yrs)
	☐ Meningococcal vaccine	
	☐ Herpes zoster vaccine (consider ≥60 yrs)	
	☐ **Hepatitis A/Hepatitis B** ☐ **Hep A immunity** ☐ **Hep B immunity**	

ASSESSMENT AND PLANS



APPENDIX G:
accompaniment to preventive care checklist for transmasculine patients

EXPLANATIONS FOR TRANS-SPECIFIC RECOMMENDATIONS

Note: This form has been adapted with permission from Dr. V. Dubey from the CFPC-endorsed Preventive Care Checklist Form©. The use of these trans-specific forms assumes familiarity with the original forms and their explanations. The original form contains graded evidence-based recommendations,[1] which may or may not be applicable to transgender patients. Unbolded recommendations should be followed as per the original forms. The specific recommendations herein represent an effort to incorporate expert opinion and limited trans-specific evidence with standard National and Provincial primary care practices in a practical format that can be accessed at the point-of-care

MEDICAL TRANSITION HISTORY

Establishment of a patient's status regarding gender-related treatments and timing of these treatments at the outset of a preventive care assessment allows for patient-centred tailoring of counselling, education, physical examination, and screening recommendations

LIFESTYLE/HABITS/PSYCHOSOCIAL

An effort should be made to assess the impact of transition/transgender identity, experiences of transphobia and impact on employment, housing, family, relationships, and economic well-being

Social Supports – specific attention should be given to assessing the extent of a patient's social supports, creating an opportunity to suggest additional resources if needed

Sexual History – delineating the types of sex that the patient is having and with whom will direct the indicated type and frequency of STI screening

Family Planning/Contraception – transmasculine patients considering hormonal treatment and/or gonadectomy should be counselled regarding the option for fertility preservation (see *Guidelines for gender-affirming primary care with trans and non-binary patients, Part I - Fertility and Birth Control*, and RHO's Reproductive Options Fact Sheet and the LGBTQ Parenting Network's 'Fertility Preservation for People Who Produce Sperm'[2])

See also potential for pregnancy/need for birth control below.

Name change/identification – assess patient need/desire to change name and/or sex marker on identification and offer support for this process (see *Guidelines for gender-affirming primary care with trans and non-binary patients, Part I - Changing Sex Designation on Government ID*, and *Appendices Q and R*)

Alcohol – due to presumed smaller liver size compared with cis men, we suggest that transmasculine patients, regardless of exogenous hormone use, follow the safe-drinking guidelines for cis women (i e maximum 10 drinks a week with no more than 2 drinks a day most days, see *Canada's Low-risk Alcohol Drinking Guidelines*)[3]

Sleep – testosterone therapy may worsen or unmask obstructive sleep apnea,[4] consider inquiring re: symptoms of sleep apnea; in those with sleep apnea, CPAP requirements may change with masculinizing hormone therapy and should be monitored

FUNCTIONAL INQUIRY

An effort should be made to use language consistent with a patient's gender identity; if unsure, consider asking the patient how they refer to their body parts

Mental Health – inquire re: experiences and impacts of transphobia; screen for mood disturbances including irritability, anger, and depression, as well as anxiety (particularly social anxiety) and self-harm; suicidal ideation and attempts are particularly high in the trans population[5] and should be specifically inquired about; inquire regarding symptoms of hypomania, mania, or psychotic symptoms in patients on testosterone who have underlying psychiatric disorders that include such symptoms; inquire re: current level of gender dysphoria and body image, (re-)assess patient interest in transition related surgeries if not undergone

Chest – inquire regarding skin changes, lumps/bumps and nipple discharge regardless of surgical status, if patient has undergone chest reconstruction, consider asking about scarring and patient satisfaction with surgical outcome (in some cases, revisions can be considered to optimize cosmetic appearance); if patient has not undergone chest reconstruction consider asking about binding (the practice of compressing chest tissue to create a flatter appearance) and any associated MSK, dermatologic, or respiratory symptoms; encourage the use of a product designed specifically for the purpose of chest binding (several commercial brands are available, for a comparison see '*Chest Binding 101*')[6] and discourage the use of other products such as tensors or duct tape; binding frequency (#days/week), and to a lesser extent binding intensity (#hours/day) have been found to be positively correlated with negative effects, suggesting that 'days off' and/or shortened duration of binding may minimize complications);[7] most manufactures recommend maximum use of 8 hours per day. Some private insurance companies will cover the cost of a commercial binder as a medical device with a prescription.

GU/PV Bleeding – inquire about symptoms of vaginal atrophy (if on testosterone), vaginal bleeding, discharge, and pelvic pain. Problematic symptoms due to vaginal atrophy often respond to topical estrogen; pelvic pain may be associated with cyclic testosterone dosing – changing the frequency/route of testosterone and/or the use of NSAIDs can be helpful (see *Guidelines for gender-affirming primary care with trans and non-binary patients, Part III - Pelvic Pain*)

NB: any unexplained vaginal bleeding once full menstrual cessation has been achieved on testosterone warrants a full work-up for endometrial hyperplasia/malignancy

Sexual Function – inquire regarding libido/hypersexual behaviour, dyspareunia (as indicated by surgical status and sexual activity), and post-orgasmic uterine cramping

Derm – inquire re: acne and androgenic alopecia, both of which may be managed as in cis patients

EDUCATION/COUNSELLING

Adequate Calcium Intake – all transmasculine patients on testosterone should ensure a minimum intake of 1200 mg of Calcium daily (diet + supplements)

Adequate Vitamin D – all transmasculine patients on testosterone should take 1000 IU of vitamin D daily

Hormone Adherence – missed doses of testosterone may impact bone health if post-oophorectomy, while extra doses may lead to a host of problems associated with supratherapeutic testosterone levels

Regular, moderate physical activity – weight-bearing exercise helps in osteoporosis prevention; to avoid tendon rupture in transmasculine individuals on testosterone weight loads used in strength training should be increased gradually with an emphasis on repetitions and stretching

Safe sex practices/STI counselling – transmasculine patients may be at high risk of STIs depending on behavioural factors; inquire re: sexual practices and risks including sex work; safer sex counselling, frequent screening (i.e. every 3 months) and an assessment of indications for HIV PrEP[8] are indicated for those at high risk. For patient-centred handout materials, see *PRIMED[2]: A Sex Guide for Trans Men into Men*[9]

Potential for pregnancy/need for birth control – transmasculine patients on testosterone (who have not undergone hysterectomy) may become pregnant even if menstrual suppression has been achieved and should be counselled in this regard; given that testosterone is a teratogen, reliable birth control should be instituted where pregnancy is a risk based on sexual activity; signs and symptoms of pregnancy can be reviewed, as well as options and resources should unplanned pregnancy occur

Need for folic acid – transmasculine patients not on testosterone and in whom pregnancy is possible based on sexual activity, as well as for those who are hoping to achieve pregnancy, folic acid recommendations are the same as for cis women

Overweight/Obese – screen for mental health contributors – persistent gender dysphoria may be associated with a desire to maintain a larger body habitus in order to hide indicators of sex assigned at birth, which may have negative health impacts; strategizing around other ways to address persistent gender dysphoria may be helpful; barriers to physical activity can also include an avoidance of gyms/locker rooms which the provider may help strategize around; screening for eating disorders is also warranted (see below)

Underweight – eating disorders are more common in LGBT2SQ populations, particularly amongst youth; screening is warranted in those presenting with BMI<18 or other related signs/symptoms

Smoking – tobacco use can worsen polycythemia (Hb/Hct above male range) which can be associated with testosterone administration, and increases the risk of CVD and thromboembolic events

Alcohol and other substances – substance use is more prevalent in members of the LGBT2SQ community; inquire re: problematic use of substances including testosterone without a prescription and anabolic steroids; if referral to substance abuse program is indicated, consider an LGBT2SQ-specific or LGBT2SQ-positive program such as *Rainbow Services at CAMH*. Offer safer smoking and injection kits when indicated for harm reduction. A naloxone kit and instructions on use should be offered to all patients who are at risk of opioid overdose, as well as friends and family of those at risk[10]

Advanced care planning – A discussion regarding advanced care planning is recommended at least once for Canadians ≥65.[11] Trans and gender diverse patients may have particular needs in ensuring that their gender identity and expression are respected and a respectful decision-maker is chosen (*See Creating End of Life Documents for Trans Individuals: An Advocate's Guide*)[12]

Injection safety – for patients who self-inject testosterone: confirm dose, review aseptic injection technique, inquire re: rotating injection sites, injection site reactions, and pre-injection anxiety; consider conversation re: SC vs. IM injection vs. transdermal route options, ensure safe sharps disposal

Bathroom safety – finding a bathroom that feels comfortable and safe can frequently be a source of stress for trans individuals. Resources such as *Refuge Restrooms*[13] can assist trans people in locating gender neutral bathrooms

PHYSICAL EXAMINATION

Chest – testosterone therapy is not thought to increase the risk of breast cancer; for transmasculine individuals who have not undergone chest reconstruction, clinical chest (i.e. breast) exam

is of questionable utility but can be considered according to a provider's common practice with cis women; transmasculine individuals who have undergone chest reconstruction are at low risk and chest and axillary lymph node exam are of questionable utility but may be considered to assess for abnormalities in the remaining breast tissue; if an abnormality is noted in this case, ultrasound +/- MRI is indicated as mammography is technically difficult or may be impossible

Pelvic/Pap – follow cervical cancer screening guidelines as for cis women if the cervix is present; there is no evidence to support the performance of a bimanual exam but if uterus and/or ovaries are present this can be considered according to the clinician's routine practice with cis women, and may be helpful in determining the appropriate width/length of speculum to use; several strategies may be employed to minimize the discomfort/trauma associated with speculum examination for some transmasculine individuals (*see Tips for Providing Paps to Trans men*).[14] Barring contraindications, topical 2% lidocaine jelly may be applied vaginally 5-10 minutes prior to the procedure in those who find speculum examination painful due to atrophic changes. The pre-procedural administration of low-dose lorazepam or the use of vaginal estrogens for 1 week prior to the exam may also be helpful

Ano-rectum – for those who engage in receptive anal sex, visual examination of the perianal region for any evidence of anal warts or other anorectal problems such as hemorrhoids should be considered; particularly those who are HIV+. Additionally consider DRE for detection of internal lesions. HIV+ patients with physical findings consistent with warts or other HPV-related changes should also be referred for HRA

Derm – examine for acne and androgenic alopecia

LABS/INVESTIGATIONS

Mammography – for transmasculine patients who have not undergone chest reconstruction, follow guidelines as for cis women; mammography is not required following chest reconstruction; for all transmasculine patients, if a strong family history of breast cancer is present, follow the same guidelines as for cis women regarding indications for referral to a high risk screening program/genetic assessment

GC/CT/Syphilis/HIV/HBV/HCV screen – consider STI detection from the following sites as indicated: throat, urethra, vagina, ano-rectum, and serum. NB: Self-collected frontal (vaginal) swabs may be more sensitive for diagnosing GC and CT than provider-collected swabs and first-catch urine[15] and may help minimize discomfort for trans patients

Cervical cytology – see Pelvic/Pap above, if patient is on testosterone, ensure to note this on the cytology requisition in order to minimize histological misinterpretation; inadequate samples are more common in patients on testosterone and repeat may be required - the use of both brush and broom may increase yield in patients with atrophic changes[16]

Yearly trans bloodwork – yearly investigations listed are for those currently on testosterone; bloodwork should be tailored to the patient's hormone regimen, risk factors and pre-existing conditions; screening for DMII and dyslipidemia should be performed at baseline and 1 year following hormone therapy initiation; and otherwise according to routine guidelines for cis patients. Framingham calculation will be less reliable with exogenous hormone use - depending on the age of hormone initiation and duration of hormone exposure providers may choose to use the risk calculator for sex assigned at birth, affirmed gender, or an average of both.[17]

> **Note**: For patients on testosterone male reference ranges should be used for Hb/Hct, however the lower limit of the female range can be used if menstruating

BMD – there is no evidence to suggest that testosterone therapy negatively impacts BMD; in accordance with national recommendations, perform bone mineral density testing in all transmasculine patients over age 65

BMD should be considered earlier in those at high risk, such as those who, for a significant period of time (i.e. >2 yrs):

- have been on low-dose or no hormones and are agonadal
- have been on a GnRH analogue without exogenous estrogen

BMD testing may additionally be considered in agonadal transmasculine patients with elevated LH.[18]
(*See 'Part III Osteoporosis and BMD Screening*')
Note: frequency of BMD screening will depend on the results of the initial scan

Anal Pap screening – for those who have a history of receptive anal sex, consider anal pap every 2-3 years or yearly in those who are HIV+ (if local HRA for the follow up of abnormal results is available). See the Canadian Cancer Society's *Colon cancer screening guidelines for gay and bisexual men* for more information

IMMUNIZATIONS

Hepatitis A/Hepatitis B – transmasculine patients may be at higher risk of Hep A/B depending on behavioural risks, trans MSM qualify for publicly funded vaccination

HPV – consider HPV vaccination in transmasculine patients up to age 45; publicly covered ≤26 yrs if sexually active with MSM

CFPC – College of Family Physicians of Canada,
STI – sexually transmitted infection,
RHO – Rainbow Health Ontario,
CPAP – continuous positive airway pressure,
MSK – musculoskeletal,
GU – genitourinary,
PV – per vagina,
NSAIDs – non-steroidal anti-inflammatories,
IU – international units,
Hb - Hemoglobin,
Hct - Hematocrit,
LGBT2SQ – lesbian, gay, bisexual, trans, queer, and two-spirit,
BMI – body mass index,
CVD – cardiovascular disease,
CAMH – Centre for Addiction and Mental Health ,
MRI – magnetic resonance imaging,
DRE - digital rectal exam, HRA - high resolution anoscopy,
HIV – human immunodeficiency virus,
GC – gonococcus,
CT – chlamydia trachomatis,
HBV – Hepatitis B virus, HCV – Hepatitis C virus,
DMII - diabetes mellitus type II,
Hb - hemoglobin, Hct - hematocrit,
BMD – bone mineral density,
LH – luteinizing hormone,
MSM – men who have sex with men,
HPV – human papillomavirus,
MSM - men who have sex with men

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APPENDIX H: glossary of terms

The following are definitions intended as useful references for this resource and for your work with trans and non- binary patients. As language is constantly evolving and seldom universally agreed upon, it is key to mirror back language people use to express their lived experience and understanding of self.

ASSUMED CIS: Previously known as **passing.** Passing is being identified as belonging to a group with more privilege and power, for instance someone who is non-disabled, white and cisgender. A trans person is "assumed cis" when they move through the world on an everyday basis with few/ no persons being aware they are trans. When one is assumed to be **cis**, the social, economic, safety and other risks associated with **cis sexist** discrimination and **transphobic** violence are decreased, thus conferring **conditional cis privilege.** Given such benefits, getting to a point where one is "assumed cis" may be a goal of one's transition, but this is not always the case. "Passing" should not be used as it implies that one is being mistaken for something they are not; it also has a particular historical meaning related to race and skin colour.

BINDING: For **transmasculine individuals**, the process of flattening one's **chest** to disguise one's "breasts." This can be done utilizing a few different things from undershirts intended for this end to lower back supports. Using an ace bandage is discouraged as it may constrict breathing. Some **transmasculine** individuals and **non-binary** people don't bind at all, some layer clothing to help hide their chests, some bind only on certain occasions and some bind all of the time.

BOTTOM SURGERY: A type of **transition-related surgery (TRS).** These are a variety of genital modification procedures, typically vaginoplasty for **transfeminine** individuals and metaoidioplasty or phalloplasty for **transmasculine individuals.**

BUTCH: A masculine form of **gender expression.** A masculine-identified person of any gender identity.

CHEST: The most common term used by **transmasculine individuals** to describe this part of their anatomy, regardless of whether they have had **top surgery** It is always important to use gender-affirming language (or at least gender-neutral language) with body parts that have a strong gender attachment.

CIS: Having a non-trans gender identity. You may also sometimes see "cissexual" or "cisgender." Thus, non-**transmasculine** individuals are "cis men" and non-**transfeminine** individuals are "cis women" It is preferable (and more accurate) to use "cis" than to use terms such as "bio", "genetic" or "real." It is also preferable to use "cis" rather than only using "woman" or "man" to describe non-trans persons. If cis is not used as a descriptor for non-trans persons, then such persons may be presumed to be the more "normal" or "valid" instantiation of that particular gender, thus contributing to **cissexism.**

CIS PRIVILEGE: The privileges afforded to those who are **cis.** In health care settings, some common experiences that reflect cis privilege include: as a patient, not worrying that providers will see their gender as less "real" or "valid" if they read through their chart and learn about their medical history; not being concerned about having tests rejected because of the "wrong" sex marker being on one's health card, and; not having to worry about questions concerning their gender distracting from care they may need that has nothing to do with gender.

CISNORMATIVITY: The assumption that all people are **cis**, i.e. that those assigned male at birth always grow up to be men and those assigned female at birth always grow up to be women. Cisnormative assumptions are so prevalent that they are difficult at first to even recognize. For example, in health care

settings cisnormativity associates “women’s health” with things such as Pap tests and contraception when, in fact, these things are relevant to many men, specifically **transmasculine** individuals.

CISSEXISM: The thoughts and actions resulting from the belief that **cis** bodies or identities are more “real” or “valid” than **trans** ones. This is distinct from **transphobia** (which denotes hatred and fear towards trans persons).

COMING OUT: Usually in reference to one’s **sexual orientation** or **gender identity.** It involves disclosing something about one’s identity that would not otherwise be known. One only has to “come out” when a heteronormative or **cisnormative** assumption (i.e. that one is “heterosexual” or “**cissexual**”) has been made about them.

CONDITIONAL CIS PRIVILEGE: The privilege experienced by **trans** persons who are often **assumed cis** in their everyday life. Such privilege is conditional on their trans identity or history not being known or revealed. Formerly referred to as “**passing privilege.**”

CROSS-DRESSER: Someone who wears clothes of another gender/sex but whose **gender identity** does not differ from the one assigned to them at birth. Most commonly, this term has been used to describe men wearing women’s clothes on a part-time basis, however some may cross-dress more frequently or all of the time. Cross-dressing may not have a fetishistic or sexual association. Some persons who practice cross-dressing may one day decide to undergo **transition.**

DIFFERENCES OF SEX DEVELOPMENT (DSD): A term used to describe the various conditions experienced by those who are intersex. Preferred by some to using “**intersex**” (regional variations exist). Also preferred over the more pathologizing term “disorders of sex development.” Persons with DSD may be **cis** or **trans** depending on how their gender identity relates to the one assigned to them at birth. “Intersex” relates to someone’s biology—it does not tell us anything about a person’s sexual orientation or gender identity.

DRAG: The performance of one or multiple genders theatrically. “Drag queens” are men performing as women; “drag kings” are women performing as men. Some persons who practice drag may one day decide to undergo gender transition.

“E“: Slang for Estrogen.

FEMME: A form of **gender expression.** A feminine identified person of any **gender identity.**

FTM: An older term to describe **transmasculine individuals**. It has fallen out of favour given its implied binary limitations and the fact that it conflates sex and **gender identity**.

GENDER AFFIRMING SURGERY (GAS): See **transition-related surgeries (TRS).**

GENDER DYSPHORIA: May refer specifically to the DSM-5 diagnosis and/or to the experience of distress associated with having one’s current gender presentation misaligned with their internal **gender identity.** Through a **medical transition, legal transition** and/or **social transition**, gender dysphoria can usually be alleviated.

GENDER EXPRESSION: The social expression of gender. Often described as being on a spectrum between **masculine** and **feminine.** Often related to, but sometimes distinct from, **gender identity.** For example, some **trans** or **cis** women may identity as **butch** or have a masculine presentation, and some cis or **transmasculine** individuals may be feminine or identity as **femme.**

GENDER IDENTITY: A person’s internal self-awareness of being a boy/man, girl/woman, something in between these, or something other altogether.

GENDER INCONGRUENCE: May refer specifically to the WHO ICD-11 diagnosis and/or to the experience of having one’s internal **gender identity** misaligned

with their sex assigned at birth. Differs from the diagnosis and concept of **gender dysphoria** in that there is no requirement for or implied experience of significant distress or impairment.

GENDER NON-CONFORMITY: When someone expresses themselves in ways that are perceived to deviate from what is socially associated with and expected from the sex they were assigned at birth.

GENDER ROLE EXPERIENCE (GRE): Previously known as the **Real Life Test** or **Real Life Experience.** According to World Professional Association of Transgender Health's Standards of Care Version 7 it is the period of time during which a trans person is required to live full time in the role of the gender they identify with prior to accessing **bottom surgery** (i.e. genital (re)constructive procedures). It is not required, and potentially dangerous, for persons to undergo a GRE prior to taking **hormone treatment** or having **top surgery.**

GENDERQUEER: A person whose **gender identity** does not align with binary gender categories such as "man/woman" or "boy/girl." Genderqueer persons often identify as a fluid gender that does not fit the male/female gender binary.

HORMONE TREATMENT: The medical management of **trans** persons with sex hormones. For **transmasculine individuals**, this is typically testosterone; for **transfeminine** individuals this may include estrogen and/or anti-androgens.

INTERSEX CONDITIONS: A subset of the "**differences of sex development**" or "disorders of sex development," in which chromosomal sex is inconsistent with genital sex, or in which the genital or gonadal sex is not classifiable as either male or female. Some individuals who report their identity as "intersex" do not have a verifiable intersex condition."[1]

LEGAL TRANSITION: The various legal identity and document changes to affirm and validate one's gender identity. This includes legal names and changes in documents and pieces of identification, such as health card, birth certificate, passport, driver's license, school transcripts, etc.

MEDICAL TRANSITION: The process of seeking and receiving various medical interventions including, but not limited to hormone therapy (including anti-androgens for **transfeminine** individuals), **transition-related surgeries** and other related surgeries (including hair transplants), and hair removal (e.g. electrolysis).

MTF: An older term to describe **transfeminine** individuals. It has fallen out of favour given its implied binary limitations and the fact that it conflates sex and gender identity.

NON-BINARY: Umbrella term for anyone who does not identify with static, binary gender identities. Includes persons who may identify as having a gender on the spectrum between girl/woman and boy/man (e.g. genderqueer), as being multiple genders, as having a constantly shifting gender, or as not having a gender altogether.

NON-DISCLOSURE: A term that applies to **trans** persons who are **assumed cis** and who choose to not share that they are trans with others. May be specific to some situations (e.g. work, sex) or applicable to all situations. Also sometimes referred to as being "stealth." Often protective as it avoids having to face **cissexist** discrimination or **transphobic** violence that can occur if others know one is trans.

NON-OP: Trans individuals not seeking any **transition-related surgery(ies).**

PACKING: The process of creating a bulge in one's crotch that leads others to believe that one may possess a penis.

PASSING: See **assumed cis**.

PASSING PRIVILEGE: See **conditional cis privilege.**

PRE-OP: Trans individuals who are seeking, but who have not undergone, one or more **transition-related surgery(ies).**

POST-OP: Trans individuals who have undergone one or more **transition-related surgery(ies).**

QUEER: A term commonly used to describe persons with non-heterosexual **sexual orientations.** More common in younger generations than terms such as “gay” or “lesbian” because of the binary nature of these older terms. Due to the historical use of queer as a derogatory term, some (particularly older adults) may continue to experience this word as offensive.

REAL LIFE TEST (RLT) OR REAL LIFE EXPERIENCE: See **Gender Role Experience (GRE)**.

SEX: Describes one’s phenotype, often determined by genital configuration. Referred to in terms of “male” or “female.” Due to **cisnormativity**, often conflated with **gender identity.**

SEXUAL ORIENTATION: Refers to the group(s) of persons that someone may desire intimate emotional and/or sexual relationships with. Examples of sexual orientations include, straight, queer, lesbian, gay, bisexual, pansexual, and asexual Everyone, **cis** or **trans**, has a sexual orientation (e.g. trans persons can be bisexual, queer, or straight).

SEX REASSIGNMENT SURGERY: See **Transition-Related Surgeries (TRS).**

SHE-MALE: A derogatory term to describe some pre-operative **transfeminine** individuals who have not undergone **transition-related surgery (TRS).**

SOCIAL TRANSITION: The various non-medical components of one’s transition that help one affirm and realize one’s **gender identity.** For example, this may include: changing one’s legal identification with changes to sex markers and name; changing the clothes one wears, and changing one’s voice, posture, and gait .

“T”: Slang for Testosterone.

TOP SURGERY: For **transmasculine individuals** involves the construction of a **chest.** For **transfeminine** individuals, it may involve breast augmentation if desired results have not been achieved with **hormone treatment** (or if they cannot, or choose to not to, take estrogen)

TRANS: Umbrella term for people who are not **cis**, includes persons who are (or identify as) **non-binary** as well as **transmasculine individuals** and **transfeminine** individuals.

TRANSFEMININE: An umbrella term to describe all persons assigned male at birth who **transition** to live as girls/women (i.e. trans women) or somewhere on the feminine spectrum.

TRANSITION: The sum total of changes involved in moving from living as one gender identity to another. Typically a stage in a **trans** person’s life. Includes **medical transition, legal transition** and **social transition.**

TRANSITION-RELATED SURGERIES (TRS): Previously known and sometimes still referred to as **sex reassignment surgery or gender reassignment surgery.** This refers to any number of surgeries that a **trans** person may undertake in order to better align their **sex** with their **gender identity.** Often assists trans persons in acquiring greater **conditional cis privilege** and in being **assumed cis.** May include both **bottom surgery(ies)** and **top surgery.** Important for some trans persons, but others may not be interested in TRS as part of their transition.

TRANSMASCULINE: An umbrella term to describe all persons assigned female at birth who **transition** to live as boys/men (i.e. trans men) or somewhere on the masculine spectrum.

TRANSPHOBIA: The fear and hatred of **trans** persons. Its expression usually involves some form of verbal, physical, and/or sexual violence. Also describes the ongoing microaggressions

experienced by those who are assumed to be trans by others in their everyday lives.

TRANSSEXUAL: Describes persons who undergo **medical transition, legal transition** and **social transition** to align the gender they live and present as with their internal **gender identity.**

TUCKING: Tucking refers to the process of concealing the penis and scrotum so that they are not conspicuous through clothing. One common method involves 'tucking' the genitalia back between the legs and binding along the perineum and/or between the buttocks.

TWO-SPIRIT: An umbrella term describing the diversity of gender expressions and sexual orientations present in traditional belief systems held by North American First Nations persons.

1. Byne W, Karasic DH, Coleman E, Eyler AE, Kidd JD, Meyer-Bahlburg HFL, et al. Gender dysphoria in adults: An overview and primer for psychiatrists. Transgender Health. 2018; 3(1):57–70.

APPENDIX I: trans health resources for primary care providers

GENERAL

- World Professional Association for Transgender Health (WPATH), www.wpath.org
  - Download a free copy of the most recent version of the Standards of Care
  - Biennial conferences on Transgender Health
  - Become a member to sign up for listserv discussions and receive the quarterly *International Journal of Transgenderism*
- Canadian Professional Association for Transgender Health (CPATH), www.cpath.ca
  - Membership, Biennial conferences
- Rainbow Health Ontario's Trans Health Knowledge Base, http://transfaqs.rainbowhealthontario.ca/
- Project ECHO: University of Toronto and the Centre for Addiction and Mental Health
  - ECHO Ontario Trans and Gender Diverse Healthcare – Supporting clients with medical and surgical transition, https://camh.echoontario.ca/trans-health/
- University of Toronto, Department of Obstetrics and Gynecology, *'The Hub' online study guide, Transgender Health,* http://thehub.utoronto.ca/obgyn/transgender-health/
- UCSF Centre of Excellence for Transgender Health, www.transhealth.ucsf.edu
  - *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People: 2nd Edition*, *http://transhealth.ucsf.edu/trans?page=guidelines-home*
  - Learning Centre (online learning, guides, reports, and fact sheets)
- Trans Care BC, http://www.phsa.ca/transcarebc
  - Resources on Trans Basics, Care & Support, Hormones, Surgery, and Children and Youth
  - *Gender-affirming Care for Trans, Two-Spirit, and Gender Diverse Patients in BC: A Primary Care Toolkit*, http://www.phsa.ca/transgender/Documents/Primary%20Care%20Toolkit.pdf

HORMONE THERAPY

- Rainbow Health Ontario Training Session: Trans and Gender Diverse Primary Care, https://www.rainbowhealthontario.ca/training/#available
- Endocrine Society Gender Dysphoria/Gender Incongruence Guideline Resources
  - *Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline,* https://academic.oup.com/jcem/article/102/11/3869/4157558
  - Clinical education resources, point of care tools and patient resources.

TRANSITION-RELATED SURGERY

- Rainbow Health Ontario Training Session: Transition-Related Surgeries - planning, referral, and care, https://www.rainbowhealthontario.ca/training/#available
- Sherbourne Health/Rainbow Health Ontario *TRS Summary Sheets*, https://www.rainbowhealthontario.ca/resources/transition-related-surgery-surgical- summary-sheets/
- Women's College Hospital TRS Program, http://www.womenscollegehospital.ca/programs-and-services/Transition-Related- Surgeries/
- Gender Reassignment Surgery (GRS) Montreal, https://www.grsmontreal.com/en/home.html
- Sherbourne Health Centre Acute Respite Care (ARC) Post-Operative TRS Program, http://sherbourne.on.ca/acute-respite-care/
- Trans Care BC - Gender Affirming Surgeries, http://www.phsa.ca/transcarebc/surgery
- Client resources:
  - *TRS FAQ*, https://www.rainbowhealthontario.ca/resources/transition-related-surgery-trs-frequently-asked-questions/
  - Sherbourne Health Centre Surgical Support Groups for Community Members, http://sherbourne.on.ca/get-involved/community-groups/

CONSULTATION AND MENTORSHIP

- Rainbow Health Ontario - Trans Health Mentorship call (https://www.rainbowhealthontario.ca/trans-health/#mentorship)
- E-consult services:
  - Ontario Telemedicine Network (OTN) https://otnhub.ca
  - Champlain LHIN eConsult Services https://www.champlainbaseeconsult.com
- TransLine: Transgender Medical Consultation Service, http://project-health.org/transline/

APPENDIX J:
reference ranges (Lifelabs)

Accurate as of Aug 7, 2019

Note: Reference ranges may vary between laboratories. It is highly recommended to compare results to reference ranges from the specific laboratory used.

17-Beta-Estradiol

	Age (yrs)		Serum level (pmol/L)
Female	14-18		<937
	>18	follicular phase	77-921
		mid-cycle	139-2382
		luteal	77-1145
		post-menopause	<103
Male	15-18		<142
	>18		<162

Luteinizing Hormone

	Age (yrs)		Serum level (IU/L)
Female	17-18		<8.5
	>18	follicular phase	2.0-12.0
		mid-cyclie	8.0-90.0
		luteal	1.0-14.0
		post-menopausal	5.0-62.0
Male	17-18		0.9-7.1
	>18		1.0-7.0

Total Testosterone

	Age (yrs)	Serum level (nmol/L)
Female	13-50	<1.8
	>50	<1.5
Male		8.4-28.8

Free Testosterone

	Age (yrs)	Serum level (pmol/L)
Female	≤10-29	<56
	≥30	<30
Male	≤10-49	196-636
	≥50	179-475

Note: The ordering of free testosterone is not routinely recommended (see *Guidelines for gender-affirming primary care with trans and non-binary patients, Part II: Monitoring and dose adjustments*). The reference ranges for free testosterone listed here are calculated via the Vermulean equation according to the current practice at Lifelabs.

APPENDIX K:
Checklist for Patient Review – Initiation of Feminizing Hormone Therapy

The decision to start hormone therapy is an individual one, based on the balance of risks and benefits for each person. In order to provide informed consent, it is important that you understand the expected feminizing changes as well the possible risks and side effects.

The use of feminizing hormone therapy (consisting of an anti-androgen and estrogen) is based on many years of experience treating trans people. A growing body of research is providing us with more information, however there are aspects of the medical effects and safety of feminizing hormone therapy that may not be fully understood.

It is possible that hormone therapy may not result in all of the changes that are hoped for.

Expected changes that can be permanent, even if you stop hormone therapy, include:

- Breast growth and development, the amount of breast tissue is variable and depends on a number of individual factors, usually breasts will become an A cup or smaller
- Genital changes - the testicles and prostate will get smaller and softer
- Infertility – the testicles will decrease (or even stop) making sperm (this may recover to a variable degree if hormones are stopped)

Expected changes that are not permanent and are likely to reverse if hormones are stopped include:

- Loss of muscle mass and strength
- Weight gain and/or redistribution of fat to the hips, buttocks, and thighs (some degree may be reversible)
- Softening of skin/decreased oiliness/change in body odour and amount of perspiration
- Decreased sex drive, decreased strength of and/or ability to get erections, decreased volume and thinning of ejaculate
- Thinning/slowing of body and facial hair growth
- Scalp hair loss may slow or stop, but hair does not generally grow back

Potential adverse effects of feminizing hormone treatment may include, but are not limited to:

- Increased risk of:
  - Blood clots (deep vein thrombosis, pulmonary embolism, and stroke)
  - Increase in liver enzymes (often temporary)
  - Decrease in, or loss of, fertility (the ability to make healthy sperm is reduced, and may be permanently affected by feminizing hormones, however you still need to use birth control if you are having penetrative sex with a partner who could become pregnant)
  - Increased triglycerides, a type of fat in the blood
  - Mood swings or depression (higher risk with cyproterone or progesterone)
  - Elevated levels of prolactin (a pituitary hormone), particularly in combination with cyproterone
- Possible increased risk of:
  - Heart disease and stroke
  - High blood pressure
  - Diabetes
  - Changes in cholesterol, which may increase risk for heart attack or stroke
  - Worsening of liver damage from other causes
  - Gallbladder disease, gallstones, and need for gallbladder removal
  - Pituitary tumours (tumor of small gland in the brain which makes prolactin)
  - Worsening of headaches or migraines

    - Breast tumours/cancer (risk is lower than in cis women, but may be higher than in cis men)
- Other common side effects include:
    - Decreased sex drive and sexual functioning
    - Fatigue

Specifically with spironolactone, adverse effects may include:

- Impaired kidney function
- Increased levels of potassium in the blood (which may cause abnormal heart rhythms)
- Low blood pressure/dizziness
- Frequent urination (especially in the beginning)
- Gastro-intestinal upset (nausea, vomiting, diarrhea)
- Rash

Specifically with cyproterone, adverse effects may include:

- Liver inflammation or acute liver failure (rare)
- Changes in blood components (low red blood cells, high platelets, or a lowering of all cell types)

Some adverse effects from hormone therapy are irreversible and can cause death.

The risks for some adverse effects may be significantly increased by:

- Pre-existing medical conditions
- Pre-existing mental health conditions
- Cigarette smoking
- Alcohol use
- Taking medication in doses that are higher than recommended

APPENDIX L:

Checklist for Patient Review –

Initiation of Progestin Therapy

Evidence suggests that the addition of a progestin to feminizing hormone regimens may increase some of the risks associated with treatment, **over and above the risks of an anti-androgen and estrogen alone**. Since there has been no demonstrated benefit to adding progestins to feminizing hormone therapy, it is not recommended in Sherbourne Health's Guidelines.

Some patients may choose to trial progestin therapy in the hopes of attaining one or more of the following anecdotal (unproven) benefits:

- Increase in libido
- Increase in breast growth
- Increase in feminizing effects through further suppression of testosterone when not adequately suppressed
- Out of desire to more closely mimic the hormones that cis women have

Potential adverse effects of adding progestin to a feminizing hormone treatment may include, but are not limited to an increased risk of:

- Blood clots (deep vein thrombosis, pulmonary embolism)
- Heart disease and stroke
- Invasive breast cancers
- Psychiatric symptoms (depression and suicidal feelings)
- Changes in cholesterol and blood pressure which may increase the risk for heart disease and stroke
- Liver inflammation
- Abdominal pain, nausea, vomiting, diarrhea or constipation
- Migraines or other headaches
- Dizziness and fatigue
- Acne
- Body hair growth
- Weight gain and bloating/fluid retention
- Joint and muscle pain

Some adverse effects from hormone therapy are irreversible and can cause death. The risks for some adverse effects may be significantly increased by:

- Pre-existing medical conditions
- Pre-existing mental health conditions
- Cigarette smoking
- Alcohol use
- Taking hormones in doses that are higher than recommended

APPENDIX M: Checklist for Patient Review – Initiation of Masculinizing Hormone Therapy

The decision to start hormone therapy is an individual one, based on the balance of risks and benefits for each person. In order to provide informed consent, it is important that you understand the expected masculinizing changes as well the possible risks and side effects.

The use of masculinizing hormone therapy is based on many years of experience treating trans people. A growing body of research is providing us with more information, however there are aspects of the medical effects and safety of masculinizing hormone therapy that may not be fully understood.

It is possible that testosterone therapy may not result in all of the changes that are hoped for.

Expected changes that can be permanent, even if you decide to stop testosterone therapy, include:

- Deepening of the pitch of your voice
- Growth of facial hair
- Increased growth, thickening, and darkening of body hair
- Possible scalp hair loss in androgenic pattern (at the temples and crown), with possible complete loss of scalp hair (baldness)
- Increase in the size of the clitoris/phallus

Expected changes that are not permanent and are likely to reverse if testosterone is stopped include:

- Menstrual periods will stop, usually within a few months of starting testosterone
- Increased muscle mass and strength
- An increase in oiliness of the skin (and sometimes acne), change in body odour
- Increased sex drive
- Weight gain and/or redistribution of fat from the hips/thighs/buttocks to the abdomen/mid-section (some degree may be irreversible)

Potential adverse effects of masculinizing hormone treatment may include, but are not limited to:

- Increased risk of:
  - Permanent reduction or loss of fertility
    - reduction of fertility is variable, and many transmasculine people have been able to conceive after stopping testosterone
    - testosterone is not reliable birth control even if your periods stop—birth control should always be used if having receptive sex with a partner who produces sperm
  - If pregnancy does occur while taking testosterone, it may cause birth defects or pregnancy loss
  - Increased number of red blood cells, which may cause headache, dizziness, confusion, visual disturbances, blood clots, heart attack, or stroke
  - Increase in liver enzymes (often temporary)
  - Severe acne
  - Changes in blood pressure and cholesterol levels which may increase the risk of heart attack and stroke (likely minimal)
  - Pelvic pain/cramping (cause not currently known)
  - Dryness and irritation of genital tissues, which may increase susceptibility to STIs including HIV

    - Sleep apnea
- Possible increased risk of:
    - Endometrial hyperplasia (overgrowth of the uterine lining, which can be a precursor to cancer)
        - It is important to let your provider know if you have a return of bleeding once bleeding has been consistently stopped by testosterone
    - Diabetes
    - Worsening of liver damage from other causes
    - Mood changes such as increase in irritability or anger, increased aggression, possible worsening of bipolar disorder, schizophrenia and psychotic disorders
    - Tendon injury

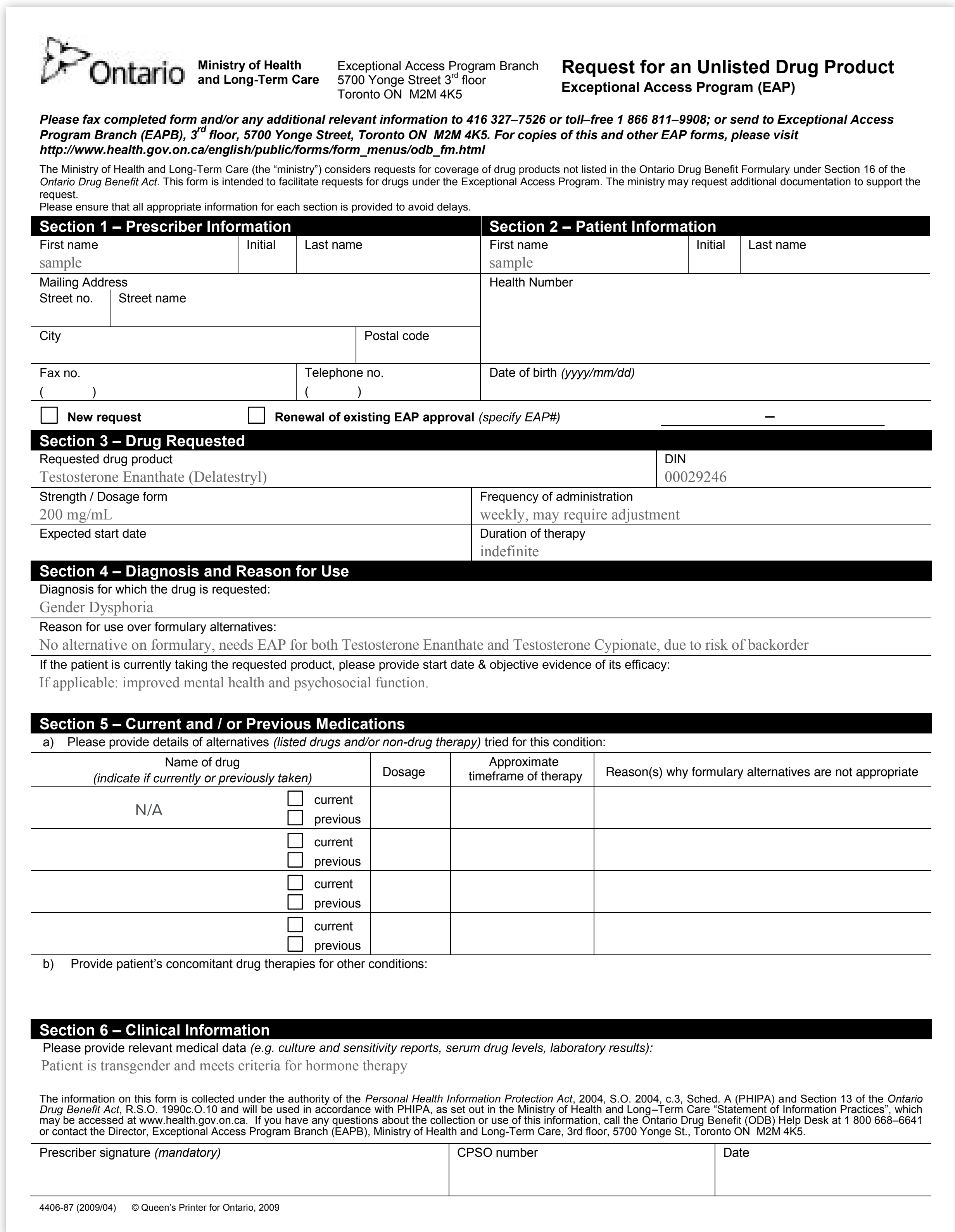
Some adverse effects from hormone therapy are irreversible and can cause death.

The risks for some adverse effects may be significantly increased by:

- Pre-existing medical conditions
- Pre-existing mental health conditions
- Cigarette smoking
- Alcohol use
- Taking testosterone in doses that are higher than recommended

APPENDIX N:

Sample Request for an Unlisted Drug Product, Testosterone Enanthate (Delatestryl)



Ontario — Ministry of Health and Long-Term Care

Exceptional Access Program Branch
5700 Yonge Street 3rd floor
Toronto ON M2M 4K5

Request for an Unlisted Drug Product
Exceptional Access Program (EAP)

Please fax completed form and/or any additional relevant information to 416 327–7526 or toll–free 1 866 811–9908; or send to Exceptional Access Program Branch (EAPB), 3rd floor, 5700 Yonge Street, Toronto ON M2M 4K5. For copies of this and other EAP forms, please visit http://www.health.gov.on.ca/english/public/forms/form_menus/odb_fm.html

The Ministry of Health and Long-Term Care (the "ministry") considers requests for coverage of drug products not listed in the Ontario Drug Benefit Formulary under Section 16 of the *Ontario Drug Benefit Act*. This form is intended to facilitate requests for drugs under the Exceptional Access Program. The ministry may request additional documentation to support the request.
Please ensure that all appropriate information for each section is provided to avoid delays.

Section 1 – Prescriber Information

First name	Initial	Last name
sample		

Mailing Address
Street no. | Street name

City | Postal code

Fax no. ( ) | Telephone no. ( )

Section 2 – Patient Information

First name	Initial	Last name
sample		

Health Number

Date of birth *(yyyy/mm/dd)*

☐ **New request** ☐ **Renewal of existing EAP approval** *(specify EAP#)* ________ – ________

Section 3 – Drug Requested

Requested drug product	DIN
Testosterone Enanthate (Delatestryl)	00029246

Strength / Dosage form	Frequency of administration
200 mg/mL	weekly, may require adjustment
Expected start date	**Duration of therapy**
	indefinite

Section 4 – Diagnosis and Reason for Use

Diagnosis for which the drug is requested:
Gender Dysphoria

Reason for use over formulary alternatives:
No alternative on formulary, needs EAP for both Testosterone Enanthate and Testosterone Cypionate, due to risk of backorder

If the patient is currently taking the requested product, please provide start date & objective evidence of its efficacy:
If applicable: improved mental health and psychosocial function.

Section 5 – Current and / or Previous Medications

a) Please provide details of alternatives *(listed drugs and/or non-drug therapy)* tried for this condition:

Name of drug *(indicate if currently or previously taken)*		Dosage	Approximate timeframe of therapy	Reason(s) why formulary alternatives are not appropriate
N/A	☐ current ☐ previous			
	☐ current ☐ previous			
	☐ current ☐ previous			
	☐ current ☐ previous			

b) Provide patient's concomitant drug therapies for other conditions:

Section 6 – Clinical Information

Please provide relevant medical data *(e.g. culture and sensitivity reports, serum drug levels, laboratory results):*
Patient is transgender and meets criteria for hormone therapy

The information on this form is collected under the authority of the *Personal Health Information Protection Act*, 2004, S.O. 2004, c.3, Sched. A (PHIPA) and Section 13 of the *Ontario Drug Benefit Act*, R.S.O. 1990c.O.10 and will be used in accordance with PHIPA, as set out in the Ministry of Health and Long–Term Care "Statement of Information Practices", which may be accessed at www.health.gov.on.ca. If you have any questions about the collection or use of this information, call the Ontario Drug Benefit (ODB) Help Desk at 1 800 668–6641 or contact the Director, Exceptional Access Program Branch (EAPB), Ministry of Health and Long-Term Care, 3rd floor, 5700 Yonge St., Toronto ON M2M 4K5.

Prescriber signature *(mandatory)*	CPSO number	Date

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APPENDIX O:

Sample Request for an Unlisted Drug Product, Testosterone Cypionate (Depo-Testosterone)

Ontario — Ministry of Health and Long-Term Care

Exceptional Access Program Branch
5700 Yonge Street 3rd floor
Toronto ON M2M 4K5

Request for an Unlisted Drug Product
Exceptional Access Program (EAP)

Please fax completed form and/or any additional relevant information to 416 327–7526 or toll–free 1 866 811–9908; or send to Exceptional Access Program Branch (EAPB), 3rd floor, 5700 Yonge Street, Toronto ON M2M 4K5. For copies of this and other EAP forms, please visit http://www.health.gov.on.ca/english/public/forms/form_menus/odb_fm.html

The Ministry of Health and Long-Term Care (the "ministry") considers requests for coverage of drug products not listed in the Ontario Drug Benefit Formulary under Section 16 of the *Ontario Drug Benefit Act*. This form is intended to facilitate requests for drugs under the Exceptional Access Program. The ministry may request additional documentation to support the request.
Please ensure that all appropriate information for each section is provided to avoid delays.

Section 1 – Prescriber Information

First name	Initial	Last name
sample		

Mailing Address

Street no.	Street name

City	Postal code

Fax no.	Telephone no.
( )	( )

Section 2 – Patient Information

First name	Initial	Last name
sample		

Health Number

Date of birth *(yyyy/mm/dd)*

☐ **New request** ☐ **Renewal of existing EAP approval** *(specify EAP#)* ________ – ________

Section 3 – Drug Requested

Requested drug product	DIN
Testosterone Cypionate (Depo-Testosterone)	00030783

Strength / Dosage form	Frequency of administration
100 mg/mL	weekly, may require adjustment

Expected start date	Duration of therapy
	indefinite

Section 4 – Diagnosis and Reason for Use

Diagnosis for which the drug is requested:
Gender Dysphoria

Reason for use over formulary alternatives:
No alternative on formulary, needs EAP for both Testosterone Enanthate and Testosterone Cypionate, due to risk of backorder

If the patient is currently taking the requested product, please provide start date & objective evidence of its efficacy:
If applicable: improved mental health and psychosocial function.

Section 5 – Current and / or Previous Medications

a) Please provide details of alternatives *(listed drugs and/or non-drug therapy)* tried for this condition:

Name of drug *(indicate if currently or previously taken)*		Dosage	Approximate timeframe of therapy	Reason(s) why formulary alternatives are not appropriate
N/A	☐ current ☐ previous			
	☐ current ☐ previous			
	☐ current ☐ previous			
	☐ current ☐ previous			

b) Provide patient's concomitant drug therapies for other conditions:

Section 6 – Clinical Information

Please provide relevant medical data *(e.g. culture and sensitivity reports, serum drug levels, laboratory results)*:
Patient is transgender and meets criteria for hormone therapy

The information on this form is collected under the authority of the *Personal Health Information Protection Act*, 2004, S.O. 2004, c.3, Sched. A (PHIPA) and Section 13 of the *Ontario Drug Benefit Act*, R.S.O. 1990c.O.10 and will be used in accordance with PHIPA, as set out in the Ministry of Health and Long–Term Care "Statement of Information Practices", which may be accessed at www.health.gov.on.ca. If you have any questions about the collection or use of this information, call the Ontario Drug Benefit (ODB) Help Desk at 1 800 668–6641 or contact the Director, Exceptional Access Program Branch (EAPB), Ministry of Health and Long-Term Care, 3rd floor, 5700 Yonge St., Toronto ON M2M 4K5.

Prescriber signature *(mandatory)*	CPSO number	Date

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APPENDIX P:
Template Letter in Support of an Application For Change of Sex Designation on an Ontario Birth Registration

Note:
- The letter must be from a **physician**, **psychologist**, or **psychological associate** authorized to practice in Canada and must be on the medical professional or clinic's letterhead providing an address and phone number
- Patient must submit an original (not photocopy) signed in blue ink by the provider.

Date: ____

To: SERVICE ONTARIO, THE OFFICE OF THE REGISTRAR GENERAL

Re: Application by (___________________________) for a change in gender designation on their birth registration.
name of patient

I am a practicing member in good standing with the ____ .
specify the appropriate regulatory body

License No: ____ .

I have provided medical/psychological support and treatment to the applicant, (____),
name of patient as shown on the birth registration

who is requesting a change in gender designation from _________________________ to _________________________ .

I confirm that the applicant's gender identity does not accord with the gender designation on the applicant's birth registration and I am of the opinion that the change of gender designation on the birth registration is appropriate.

Yours truly,

____
signature and name of provider

APPENDIX Q:
Template Letter in Support of an Application For Change of Sex Designation on an Ontario Driver's License

Note: • The letter must be from a **physician**, **psychologist**, or **psychological associate** authorized to practice in Canada and must be on the medical professional or clinic's letterhead providing an address and phone number.
• Patient must submit an original (not photocopy) signed in blue ink by the provider.

Date: ____

To: THE ONTARIO MINISTRY OF TRANSPORTATION

Re: Application by (___________________________) for a change in gender designation on their driver's license.
name of patient

I am a practicing member in good standing with the ____.
specify the appropriate regulatory body

License No: ____.

I have evaluated the applicant, (____), who is requesting
name of patient as shown on the driver's license

a change in gender designation from _________________________ to _________________________.

I confirm that the applicant's gender identity does not accord with the gender designation on the Applicant's driver's license and I am of the opinion that the change of gender designation on the driver's license is appropriate.

Yours truly,

____
signature and name of provider

APPENDIX R:

Sample Support Letter for Trans Clients Applying for EI through the Just Cause Mechanism

---

Date: ____

To: Human Resources & Skill Development

Re: Application by (____________________________) for Employment Insurance benefits.
name of patient

My *(patient/client)* is a *(transgender woman, transgender man, gender fluid person, etc.)* As a transgender person, *(he/she/they)* report experiencing severe and prolonged mistreatment in *(his/her/their)* workplace, including:
Edit details to accurately reflect patient's case, providing as much specific detail as possible; the types of incidents commonly reported include:

- Breach of privacy and threat to safety through the non-consensual disclosure of transgender status by a co-worker/supervisor to others in the workplace
- Verbal harassment, including derogatory jokes and transphobic comments by other co-workers
- Deliberate and repeated use of the wrong gender pronoun by co-workers and supervisor – a practice which is considered harassment by anti-discrimination legislation in some jurisdictions
- Threats to the safety of self or loved ones by co-workers and customers
- Significant change to work duties and reduction of hours of work following disclosure or discovery of transgender status
- Sexual harassment following disclosure or discovery of transgender status
- Persistent hostility by the supervisor following disclosure or discovery of transgender status
- Pressure on the claimant to leave employment and pursue other work

I believe this meets the criteria for 'just cause' outlined in paragraph 29(c) of the Employment Insurance Act, as my patient had no reasonable alternative to leaving to ensure *(his/her/their)* safety and dignity.

Please feel free to contact me if you require any additional information.

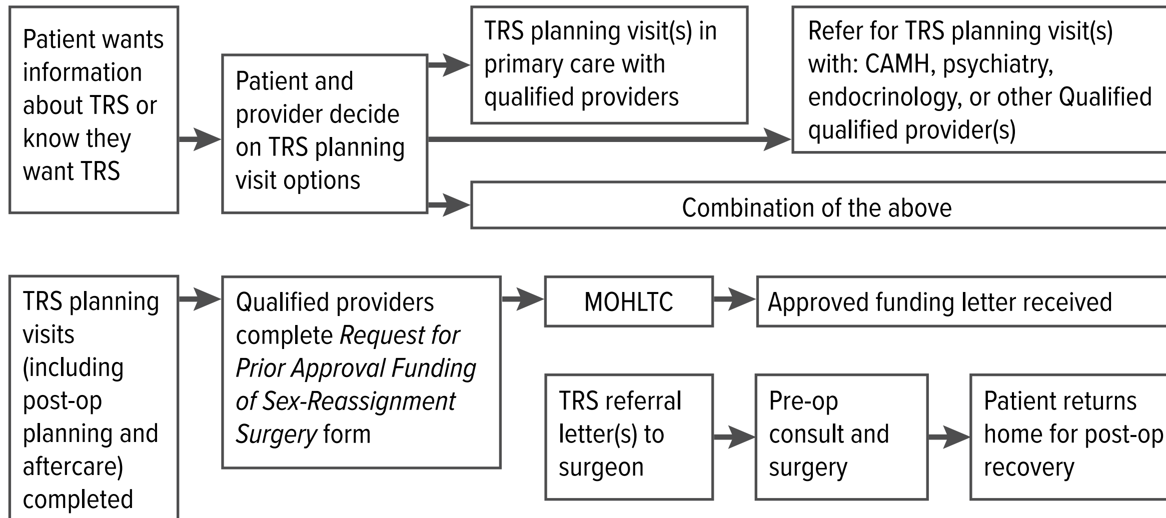
Yours truly,

____
signature and name of provider

APPENDIX S:

Transition Related Surgery: System Flowsheet

Providers can gain TRS knowledge through: WPATH SOC; RHO Surgery Workshops; RHO Trans Mentorship call; Sherbourne Health Surgical Summary sheets; UofT/CAMH Trans ECHO; Trans E-consult with the Champlain LHIN; and/or mentorship with an experienced provider.



Whether or not they provide TRS planning visits, there are many ways that providers can support patients during the TRS process:

Initial Stages:

Provide client with TRS FAQ

Help navigate system and process

Give list of MOHLTC covered transition-related surgeries and give a list of surgeons providing TRS

Pre-op Planning and Care:

Complete Pre-op forms and bloodwork

Connect with local surgeon in case of complications

Discuss aftercare plan, travel, supplies

Trans pre-surgical support groups

Planning for Aftercare:

Arrange post-op visits in primary care

Arrange post-op care at Sherbourne ARC

Arrange home and community care

Post-op Care:

Trans post-surgical support groups

Help manage complications and long term care

TRS – Transition-related surgery(ies)
CAMH – Centre for Addiction and Mental Health
MOHLTC – Ministry of Health and Long-term Care
WPATH SOC – World Professional Association for Transgender Health – Standards of Care
RHO – Rainbow Health Ontario, a program of Sherbourne Health
U of T – University of Toronto
LHIN – Local Health Integration Network