

## Main Line Health Comprehensive Gender Care Program

### LETTERS OF READINESS FOR GENDER-AFFIRMING SURGERY

The Main Line Health gender services surgical team follows the World Professional Association for Transgender Health (WPATH) standards of care, which outline criteria for certain gender-affirming surgeries, including letters of readiness.

For letters of readiness, please use the template below, making sure to include:

- Two patient identifiers (legal name/name on insurance, date of birth)
- The specific surgical procedure the patient needs
- The name of the provider who is available for coordination of care before, during, and after surgery

To submit a letter of readiness:

- Upload to Main Line Health MyChart [or](#)
- FAX to Comprehensive Gender Care Program at [484.337.6333](tel:484.337.6333)

If you have questions or need further assistance, please contact the gender services navigator at [484.337.5329](tel:484.337.5329).

## SAMPLE LETTER

[must be on letterhead]

[date]

Re: [patient name on insurance card], [patient's chosen name], [patient DOB]

To whom it may concern:

[Patient name] is a patient in my care at [your practice name]. They have been a patient here since [date]. They identify as [gender identity] and go by [pronouns]. They note that they first knew their gender identity differed from their assigned sex at age [age]. They have socially transitioned by [list how—changed name, pronouns, dress, make-up, hair, tuck, pack, binding, coming out, etc]. They have successfully and consistently been living in a gender role congruent with their affirmed gender since [date]. They have consistently been on hormone therapy since [date]. [NOTE: If contraindicated or patient chose not to take hormones, state here.] Despite these interventions, they report significant anxiety, depression, and distress due to their experience of dysphoria. By my independent evaluation of [patient name], I diagnosed them with Gender Dysphoria (ICD-10 F64.1). They have expressed a persistent desire for [type of surgery]. Their goals of surgery are [state goals]. Surgery will address their gender dysphoria in these ways: [explain].

[Patient name] is psychologically stable to undergo this surgery. [List any mental health diagnoses that may be relevant to having surgery.] They are stably housed and have prepared for their post-op recovery. [NOTE: Include if this is true; if not true, state plan for post-op recovery.] They have no issues with illicit drug use or abuse. [NOTE: Include if this is true; if it is not true, explain plan of care for stabilization.]

[Patient name] has more than met the WPATH criteria for [type of surgery]. I have explained the risks, benefits, and alternatives of this surgery and believe they have an excellent understanding of them. They are capable of making an informed decision about undertaking surgery. I believe that the next appropriate step for them is to undergo [type of surgery], and I believe this will help them make significant progress in further treating their gender dysphoria. Therefore, I hereby recommend and refer [patient name] to have this surgery.

If you have any questions or concerns, please do not hesitate to contact me.

Sincerely,

[your name and credentials]

[your phone number]

[your license number]