Appendix M: Consent Form for Masculinizing Hormone Therapy

Initiation of Care

A. The full medical effects and safety of hormone therapy are not fully known. Potential adverse effects may include, but are not limited to:

- Increased cholesterol and/or fats in the blood, which may increase risk for heart attack or stroke
- Increased number of red blood cells (increased hemoglobin), which may cause headache, dizziness, heart attack, confusion, visual disturbances, or stroke
- Acne
- Increased risk of the following:
  - Heart disease and stroke
  - High blood pressure
  - Liver inflammation
  - Increased or decreased sex drive and sexual functioning, shifts in sexual attraction/ orientation
  - Psychiatric symptoms such as depression and suicidal feelings; anxiety; psychosis (disorganization and loss of touch with reality), and worsening of pre-existing psychiatric illnesses

B. Some side effects from hormones are irreversible and can cause death.

C. The risks for some of the above adverse events may be INCREASED by

- Pre-existing medical conditions
- Pre-existing psychiatric conditions
- Cigarette smoking
- Alcohol use

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

- Deepening of voice
- Development of facial & body hair
- Fat redistribution
- Genital changes (i.e. enlargement of clitoris & labia, vaginal dryness)
- Infertility
- Male pattern baldness

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

____

(name of care provider)

has discussed with me the nature and purpose of hormone therapy; the benefits and risks, including the risk that hormone therapy may not accomplish the desired objective; the possible or likely consequences of hormone therapy; and other alternative diagnostic or treatment options.

- ❑ I have read and understand the above information regarding the hormone therapy, and accept the risks involved.
- ❑ I have had sufficient opportunity to discuss my condition and treatment with my medical provider, and all of my questions have been answered to my satisfaction.
- ❑ I believe I have adequate knowledge on which to base an informed consent to the provision of hormone therapy.
- ❑ I authorize and give my informed consent to the provision of hormone therapy.

____

Signature of Witness

____

Date

____

Name of Witness (Printed)

____

Signature of Client

____

Date

____

Legal Name of Client (Printed)