To Whom It May Concern,

Please accept this letter and the attached application as my recommendation for the above-named patient for gender-affirming [TYPE OF SURGERY]

I have met with [PT NAME] for transition-related surgery planning assessments regarding this surgery. After discussing their gender history, medical and mental health history, nature of the surgery and its risks and benefits, alternative treatments and aftercare planning, I have found that [PT NAME] meets all of the WPATH criteria for surgery which include:

[WPATH STANDARDS FOR SURGERY (pg 256 in WPATH8) ]  
  
**GENDER DYSPHORIA HISTORY  
(as related to pt. including any of the following details if applicable. If not, can skip section:**They have been utilizing [HRT, duration]  
They have previously completed other gender-affirming surgeries including: [previous surgeries].

[PT NAME] has experienced significant benefit from the gender-affirming treatments they have received to date including reduced dysphoria and improved mental health. [PT NAME] continues to experience gender dysphoria related to [Specify as applies to pt] and feels ready to proceed with [TYPE OF SURGERY]

**Medical History:   
  
Mental health history:   
  
Surgical History:   
  
Medications:   
  
Allergies:**In summary, [PT NAME] is a good candidate for gender-affirming surgery. They meet all WPATH criteria for surgery, have realistic expectations, are prepared for surgery from a medical and mental health perspective, and have an appropriate aftercare plan in place. I hereby recommend this patient for gender-affirming [TYPE OF SURGERY]

I am a Family Physician in good standing with the College of Physicians and Surgeons of Ontario. **[Can include additional details such as:** training and experience in the management of gender dysphoria, knowledge of the WPATH Standards of Care, length of time providing gender-affirming care.]

Please feel free to contact me if you require further information. I look forward to working with you to coordinate care for this patient.

Thank you,  
  
Billing No.  
CPSO:   
[Clinic/Contact Details]