BCCH GENDER CLINIC
Gender Clinic: 604-875-2345 x6550
Toll-free Phone: 1-888-300-3088 x6550
Fax: 604-875-2426
http://endodiab.bcchildrens.ca
bcchgenderclinic@cw.bc.ca

INFORMED CONSENT FORM: MATURE MINOR
ESTROGEN FOR ASSIGNED MALES WITH GENDER DYSPHORIA

I am receiving treatment for gender dysphoria. The cause of gender dysphoria is not known. I understand that the effect of this on me means that, even though I think of myself as non-binary or as partially or completely feminine, I have genetic, biological and physical masculine traits. I want to receive treatment that will help feminize my body, so that it will match my sense of myself (gender identity).

I understand that I have had a hormone-readiness assessment from a qualified provider and that I am deemed eligible and ready to begin taking estrogen.

I have been provided a copy of the clinic's information sheet *Estrogen for Assigned Males with Gender Dysphoria*. I have had a chance to read over this document. I have also had the opportunity to go over this document in detail with my gender doctor, and they have answered all my questions and addressed all my concerns.

I agree to take estrogen as prescribed. I agree to tell my doctor if I am not happy with the treatment or am experiencing any problems. I understand that the right dose or type of medication prescribed for me may not be the same as for someone else. I understand that physical examinations and blood tests are needed on a regular basis to check for the positive and negative effects of estrogen. I have been told that I will continue to get medical care no matter what information is shared. I understand that I may choose to stop taking estrogen at any time, and that it is best that this is done with the help of my doctor, to make sure there are no negative reactions to stopping. I understand that my doctor may suggest I decrease or stop taking estrogen, or switch to another type of feminizing medication, if there are severe side-effects or health risks that can't be controlled.

My signature below confirms that:

- My doctor has talked with me about the benefits and risks of estrogen, the possible or likely consequences of hormone therapy, and any potential alternative treatment options.
- I understand the risks that may be involved.
- I understand that the information provided to me covers known effects and risks, and that there may be long-term effects or risks that are not yet known.
- I have had the opportunity to discuss treatment options with my doctor. All of my questions have been answered.
- I believe that I have enough knowledge to provide informed consent to take estrogen therapy.

Based on this, I wish to begin taking estrogen.

_____

PLEASE WRITE OUT YOUR NAME Date of Birth

_____

Patient Signature Date

_____

Witness Signature Date

_____

Physician Signature Date