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

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

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

I/We understand that my/our youth has had a hormone-readiness assessment from a qualified provider and that they are deemed eligible and ready to begin taking estrogen.

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

I/we agree for my/our youth to take estrogen as prescribed. I/We agree to tell my/our youth's doctor if they are not happy with the treatment or are experiencing any problems. I/we understand that the right dose or type of medication prescribed for my/our youth may not be the same as for someone else. I/we understand that physical examinations and blood tests are needed on a regular basis to check for the positive and negative effects of estrogen. I/we have been told that my/our youth will continue to get medical care no matter what information is shared. I/we understand that my/our youth may choose to stop taking estrogen at any time, and that it is best that this is done with the help of my/our youth's doctor, to make sure there are no negative reactions to stopping. I/we understand that my/our youth's doctor may suggest they 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/Our signature below confirms that:

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

Based on this, I/we wish for my/our youth to begin taking estrogen.

_____

PLEASE WRITE OUT YOUTH'S NAME Date of Birth

_____

Parent/Guardian #1 Signature Date

_____

Parent/Guardian #2 Signature Date

_____

Witness Signature Date

_____

Physician Signature Date

I understand that my parent(s) or legal guardian(s) have consented for me to begin taking estrogen. I have had this consent form explained to me, and I agree to treatment with estrogen.

_____

Patient Signature Date