

## **INFORMED CONSENT FORM: MATURE MINOR PUBERTY BLOCKERS FOR ASSIGNED FEMALES 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 masculine, I have genetic, biological and physical feminine traits. I want to receive treatment that will help my body stop having the changes of female puberty. This will allow me time to continue my gender journey without having to worry about unwanted, permanent female body changes.

I understand that I have had a puberty blocker–readiness assessment from a qualified provider and that I am deemed eligible and ready to begin taking puberty blockers.

I have been provided a copy of the clinic's information sheet *Puberty Blockers for Assigned Females 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 puberty blockers 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 puberty blockers. 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 puberty blockers 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 puberty blockers, or switch to another type of masculinizing 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 puberty blockers, 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 puberty blockers therapy.

***Informed Consent Form: Mature Minor: Puberty Blockers for Assigned Females with Gender Dysphoria (continued)***

Based on this, I wish to begin taking puberty blockers.

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PLEASE WRITE OUT YOUR NAME Date of Birth

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Patient Signature Date

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Witness Signature Date

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Physician Signature Date