**Area Office Request Form**

**Consent for Puberty Blocking Agents/Gender-Affirming Hormone Therapy**

All requests for puberty blocking agents and gender-affirming hormone therapy will be reviewed by the Office of the Medical Director within 20 working days. Please complete the following form to the best of your ability and submit the form to your Regional Nurse for review. If available, please also include the clinic notes/medical record from the identified provider.

**Date of Request:** Enter Request Date

**Requesting**: [ ] Puberty-blockers [ ]  Gender-affirming medication

**Youth Name:** Click or tap here to enter text. **DOB:** Click or tap here to enter text.

**Current Placement**: Click or tap here to enter text.

**Name of Requesting Medical Provider:** Click or tap here to enter text.

**Location of Practice:** Click or tap here to enter text.

**Requesting Medical Provider’s Contact Information:** Click or tap here to enter text.

**Social Worker completing form:** Click or tap here to enter text.

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**Medical Record Requests**

Medical record/ clinic notes has been received: [ ]  Yes, received [ ]  Requested, not received

[ ]  Not yet requested. Comments: Click or tap here to enter text.

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**For Gender-affirming Hormone Therapy requests ONLY:**

Communication from mental health provider has been received:

[ ]  Yes received [ ]  Requested, not received [ ]  Not yet requested

Comments: Click or tap here to enter text.

Did the youth’s medical provider discuss fertility preservation with the youth? [ ]  Yes [ ]  No

Comments: Click or tap here to enter text.

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**When parental rights have NOT been terminated, has there been documented verbal communication with the parent(s)/guardian(s)regarding the use of puberty blocking agents or gender-affirming medication:**

[ ]  Yes, there is documented communication with the parent(s)/guardian(s)

[ ] This step is in process

[ ]  No, communication with parents has not occurred

[ ]  No, communication with parents has not occurred at youth’s request (for puberty blockers only)

Comments: Click or tap here to enter text.

**When communication has occurred, please document your understanding of the parents’ wishes:** Click or tap here to enter text.

**Briefly describe the youth’s involvement with the Department and any relevant information from their or their family’s Action Plan:** Click or tap here to enter text.

**Have there been or are there currently any safety concerns?** **If so, please fill out below.**

Violence: [ ]  None [ ]  Violence toward others [ ]  Fire setting [ ]  Cruelty toward animals

[ ]  Other (please specify): Click or tap here to enter text.

Self-harm: [ ]  None [ ]  Cutting [ ]  Burning

[ ]  Other (please specify): Click or tap here to enter text.

Suicidality: [ ]  None [ ]  Past SI [ ]  Current passive ideations [ ]  Current active SI with plan

[x]  Past suicide attempt [ ]  2 or more suicide attempts [ ] Other (please specify): Click or tap here to enter text.

Psychiatric Hospitalization: [ ]  None [ ]  Psych hospitalization within last 3mo

[ ]  Psych hospitalization within the last year [ ]  Past psych great then 1 year

[ ]  Multiple hospitalizations [ ]  Other (please specify): Click or tap here to enter text.

Comments regarding safety/risk: Click or tap here to enter text.

**Have there been or are there currently any concerns for substance use? If so, please specify:** Click or tap here to enter text.

**Does the youth have any of the support systems below? Please check all that apply.**

[ ]  Relationship with family of origin [ ]  Peer friendships

[ ]  Participation in extracurricular activities/ sports [ ]  Supportive adult relationship

[ ]  Engagement in services [ ]  Active referrals for service

[ ]  Spiritual or religious community supports [ ]  Other community supports

Comments: Click or tap here to enter text.

**Please provide any additional information you have about this youth, including strengths and other collateral information:** Click or tap here to enter text.

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I have discussed this request for [ ]  Puberty blocking agents [ ]  Gender-affirming hormone therapy with this youth and youth agrees with the current treatment plan.

Social Worker Signature Date

Click or tap here to enter text.

Printed Name

Supervisor Signature Date

Click or tap here to enter text.

Printed Name