**Mental Health Information for Gender-Affirming Hormone Consent**

Dear Mental Health Provider,

Re:Click or tap here to enter text. Date of Birth: Click or tap here to enter text.

 (Youth’s Name)

This youth is currently requesting to receive gender-affirming hormone treatment. We are requesting mental health information from you regarding your work with this youth and invite you to have a collaborative role in this medical and mental health review.

For youth in DCF custody, there are specific guidelines regarding the mental health requirements for youth who are seeking gender affirming agents to help streamline appropriate access to these treatments. You will find a copy of these guidelines attached to this request.

**To help inform the Departments ability to consent to gender-affirming agents for this youth, we ask that you respond to the questions below. This form can be completed electronically.**

Thank you for your time and continued work with this youth. Please feel free to reach out if you have any questions.

Sincerely,

Social worker name: Click or tap here to enter text.

Massachusetts Department of Children & Families

Click or tap here to enter text. Area Office

Phone:Click or tap here to enter text.

Email:Click or tap here to enter text.

Date:Click or tap here to enter text.

**Mental health provider Information:**

Name:Click or tap here to enter text. Practice Name & Address:Click or tap here to enter text.

E-Mail:Click or tap here to enter text. Telephone: Click or tap here to enter text.

If the youth is on medication, the prescriber name and phone number: Click or tap here to enter text.

How many years have you been in practice? (**click box to check electronically**)

[ ] -5 [ ] 6-10 [ ] 11-15 [ ]  20+

What type of specific training have you had on the mental health needs of Transgender/Gender Non-Conforming population?

[ ] Conference [ ]  Webinar [ ]  Supervision [ ]  Lecture/grand rounds [ ] Other (please specify):

Click or tap here to enter text.

Please rate your level of expertise working with Transgender/Gender Non-Conforming youth:

[ ] Novice learner [ ] Moderate experience [ ]  Expert provider [ ]  Other (please specify):

Click or tap here to enter text.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Youth Information:**

Birth Name: Click or tap here to enter text.

Affirmed Name (if applicable) Click or tap here to enter text.

Sex Assigned at Birth:Click or tap here to enter text.

Affirmed Gender: Click or tap here to enter text.

Date of First Therapy Session:Click or tap here to enter text.

Frequency of Visits: Click or tap here to enter text.

Current Mental Health Diagnoses: Click or tap here to enter text.

Have you communicated with:[ ]  School [ ]  Caregiver [ ] DCF [ ] PCP [ ] Psychiatric Provider

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

**Gender:**

For how long has the youth reported as identifying as transgender or gender diverse?

Click or tap here to enter text.

What symptoms are being addressed in therapy? How does the youth identifying as transgender or gender diverse impact these symptoms?

Click or tap here to enter text.

**General History:**

Youth’s Strengths: Click or tap here to enter text.

Support System (caregiver, community support groups, friends, school system, religious affiliation):

Click or tap here to enter text.

Child welfare involvement & impact on mental health: Click or tap here to enter text.

What is the youth’s current relationship with their family of origin?Click or tap here to enter text.

Developmental issues (if known): Click or tap here to enter text.

Trauma history: Click or tap here to enter text.

Trauma work in therapy (if applicable): Click or tap here to enter text.

**Safety:** Please check the box corresponding to any safety concerns

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

[ ] 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.

**Substance Use:**

Active: Yes [ ] /No [ ]

If yes, please list substance youth is actively using:Click or tap here to enter text.

Past: Yes [ ] /No [ ]

If yes, please list substances youth has used in the past: Click or tap here to enter text.

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

**Therapist Clinical Impressions:**

Do you think the youth would experience benefits as a result of gender affirming treatment? Please explain: Click or tap here to enter text.

Do you have concerns with the youth moving forward with gender affirming treatment? Please explain: Click or tap here to enter text.

Is the youth currently seeing another mental health professional? If so, is this person in agreement with moving forward with gender-affirming treatment at this time? Click or tap here to enter text.

Provider Recommendation: Click or tap here to enter text.

 Enter Date

Provider Signature Date

Click or tap here to enter text.

Print Name