

INFORMED CONSENT FOR TESTOSTERONE THERAPY

For Female to Male Transition Fenway Community Health – Transgender Health Program

This form refers to the use of testosterone by persons who wish to become more masculinized as part of a gender transitioning process.

Your initials of the various statements on this form indicate that the risks as well as the changes which may occur as a result of the use of testosterone have been explained to you and that you understand them. If you have questions or concerns about this information, you are encouraged to take the time you need to ask for clarification, read, research, talk with staff, and think about the potential effects of this treatment before signing.

IF YOU DO NOT UNDERSTAND THIS INFORMATION STOP AND ASK FOR CLARIFICATION

Please initial and date each section below to indicate that you understand and agree with the statements.

_____ 1. I have been informed that the masculinizing effects of testosterone therapy may take several months to become noticeable and more than five (5) years to be complete. Some of these changes will be permanent including:

- * Hair loss, especially at my temples and crown of my head, possibly male pattern baldness
- * Facial hair growth (i.e., beard, mustache)
- * Deepening of my voice
- * Increased body hair growth (i.e., on arms, legs, chest, back, buttocks, and abdomen, etc.)
- * Enlargement of my clitoris

These additional changes will not be permanent if I stop testosterone therapy:

- * Redistribution of fat to a male pattern (i.e., abdominal fat may increase while fat in the breasts, buttocks, and thighs may decrease)
- * Increased muscle development
- * Increased red blood cells
- * Increased sex drive and energy levels. Possibly increased feelings of aggression or anger
- * Acne, which may become severe and may require treatment
- * Cessation of menstrual cycles (periods) and suspended ovulation (maturing of ova) including changes to/thinning of your vaginal tissue/lining leading to increased potential for easy damage, dryness, or yeast infections

_____ 2. I understand that it is not known exactly what the effects of testosterone are on fertility. I have been informed that if I stop taking testosterone, I may not be able to become pregnant in the future. I have been advised to undergo gamete (egg) banking if this is a concern of mine.

_____ 3. I understand that brain structures are affected by testosterone and estrogen. The long term effects of changing the levels of one's natal estrogen through the use of testosterone therapy have not been scientifically studied and are impossible to predict. These effects may be beneficial, damaging, or both.

_____ 4. I understand that everyone's body is different and that there is no way to predict what my response to hormones will be. I also understand that the right dosage for me may not be the same as for someone else. I further understand that I must follow *my* prescribed regimen of testosterone treatment to continue to receive hormone therapy at this clinic.

_____ 5. I will have complete physical examinations and lab tests periodically as required to make sure I am not having an adverse reaction to testosterone and to continue good health care. I understand that this is required to continue testosterone therapy at this health center.

_____ 6. I have been informed that using testosterone may increase my risk of developing diabetes in the future because of changes in my ovaries.

_____ 7. I understand that the endometrium (lining of the uterus) is able to turn testosterone into estrogen and may increase the risk of cancer of the endometrium. Not having periods may increase this risk. Continued pelvic exams and cervical cancer screenings are strongly recommended unless there has been a removal of the ovaries, uterus, and cervix.

8. I understand that testosterone therapy should not be relied upon to prevent pregnancy. Even with the cessation of periods, use of a barrier method of birth control is advised during sex where semen could enter the vagina or uterus.
9. I understand the effects of testosterone therapy by itself will not provide protection from sexually transmitted diseases or HIV. Use of barriers and safer sexual practices are recommended to reduce chances of infections.
10. The effects of testosterone therapy do not provide protection from cervical or breast cancer. Annual breast exams, monthly self-exams, and annual mammograms/cancer screenings after the age of 40 are highly recommended even after chest reconstruction.
11. I understand fatty tissue in the breasts and body is able to turn excess testosterone into estrogen, which may increase my risk of breast cancer and decrease or impede the desired effects of testosterone therapy.
12. I have been informed that testosterone may lead to liver inflammation and damage. I have been informed that I will be monitored for liver problems before starting testosterone therapy and periodically during therapy.
13. I have been informed that if I take testosterone my good cholesterol (HDL) will probably go down and bad cholesterol (LDL) will go up. This may increase my risk of heart attack or stroke in the future. The rates for FTMs on testosterone are similar to that of natal males.
14. I understand that testosterone therapy may cause changes in my emotions and moods and that my providers can assist me to find support services and other resources to explore and cope with these changes.
15. I agree that if I have any adverse reactions or side effects to testosterone I will inform my health care provider.
16. I agree to tell my provider about any non-clinic hormones, dietary supplements, herbs, recreational drugs, or medications I might be taking. Sharing this information will help my provider to prevent potentially harmful interactions. I have been informed that staff will continue to provide me with medical care, regardless of what information I share with them.
17. I agree to take testosterone *as prescribed* and to inform my provider of any problems or dissatisfaction I may have with my treatment. I understand that if I take too much testosterone my body may convert it to estrogen.
18. I understand that there are medical conditions that could make taking testosterone either dangerous or physically damaging. I agree that if clinic staff suspect I may have any condition that could be dangerous to me, I will be evaluated for it before the decision to start or continue testosterone therapy is made. I understand that if I do not agree to be evaluated, my prescription for testosterone may be cancelled or refused.
19. I understand that I can choose to stop taking testosterone at any time. I also understand that my provider can discontinue treatment for clinical reasons. I agree to follow a prescribed reduction plan if either of these situations occurs to reduce negative and potentially harmful side effects that may occur if I suddenly stop taking testosterone.

All the information above has been explained to my satisfaction AND (check only one)

I choose to begin Testosterone therapy. I do not wish to begin Testosterone therapy at this time.

Patient Signature

Patient Name Printed

Date

Medical Provider Signature

Provider Name Printed

Date