To Dr. Chen and the Surgical Team:

I am writing to formally refer and recommend my patient, **[Patient Name]**, for **[Select: Phalloplasty / Metoidioplasty]** surgery.

I have been treating [Patient Name] since [Date of first visit] in the capacity of [Therapist/Psychologist/Counselor]. Based on my comprehensive clinical evaluation, [Patient Name] meets the medical necessity criteria for this procedure.

1. Diagnosis & Clinical History [Patient Name] carries a diagnosis of **Gender Dysphoria (F64.0)**. He presents with a persistent and well-documented history of gender dysphoria that has been present since [childhood/adolescence]. The incongruence between his experienced gender and his assigned sex at birth causes clinically significant distress, which this surgical intervention is required to resolve.

2. Duration of Therapy & Social Role The patient has maintained a regimen of hormone replacement therapy (testosterone) since [Date], covering a period exceeding 12 months. This treatment has resulted in congruent physical characteristics and a marked reduction in dysphoria.

Additionally, [Patient Name] has lived full-time in a gender role congruent with his identity for over 12 months. He has successfully navigated social transition across all domains of his life, including work and family environments.

3. Cognitive Capacity & Stability [Patient Name] is of the age of majority and demonstrates the full cognitive capacity to provide informed consent. He is free from any uncontrolled mental health conditions that would impair his judgment or ability to adhere to post-operative care instructions.

4. Informed Consent & Expectations We have reviewed the implications of [Phalloplasty/Metoidioplasty] in detail. The patient unequivocally understands:

- The irreversible and permanent nature of the surgery.
- The complexity of the procedure and the anticipated recovery timeline.
- The potential surgical risks and complications.

[Patient Name] has established a solid post-operative care plan, including confirmed housing and caregiver support.

It is my independent professional opinion that this surgery is medically necessary and appropriate for [Patient Name].

Sincerely,

[Signature]

[Provider Printed Name, Credentials] [License Number] [Contact Information]