15506 S. Telegraph Rd, **Monroe**, MI 48161
2702 Navarre Ave. #106, **Oregon**, OH 43616
6855 Spring Valley Drive #150, **Holland**, OH 43528

Endocrine Specialists, PC
M. Moosa, MD

P: 734-682-5243 or 419-724-0004 | **F**: 888-677-1987 Call@EndoMDs.com www.EndoMDs.com

TRANSMAN INITIAL VISIT

Welcome! It is a pleasure to be of service to you. To help us provide you with the best transgender medical care, we need you to bring the following:

A. **Transman Initial Visit Packet:** You can download this packet from our website at www.EndoMDs.com. You will find it under "Forms". Please print it, and bring it with you to your initial visit. This packet includes:

1. Transman Initial Visit: (this document) It lists and explains the items that you need to bring to your initial visit.
2. Transgender Medical History: Please answer questions related to your transgender medical history.
3. Ohio BMV Declaration of Gender Change: We will fill it out/sign it for you to help you change your gender on your driver's license.
4. Letter Certifying Gender Change: We sign that letter for you to carry in public places to help prevent difficulties you could have with the authorities.
5. Consent For Testosterone For Transmen: You need to read this carefully, discuss with the doctor, then initial/sign it; it will then be be cosigned by your doctor and added to your records.
6. Transgender Medical FAQ: Please read carefully; this will inform you on how we conduct your transgender medical care.
7. Masculinizing Medical Therapy Expected Results: These help set your expectations regarding the results of your transgender medical therapy.

B. **Letter From Your Mental Health Provider** (MHP), i.e. Psychologist/Therapist. This is to certify that you are ready to receive transgender hormones/medications.

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TRANSGENDER MEDICAL HISTORY

IMPORTANT NOTE:

Some of the following questions are sensitive. Please answer only what you are comfortable with; your answers will help us identify hidden medical problems and prevent future ones.

Check all applicable options:

1. What is your preferred first name? _____
2. Are you: ☐ Transman ☐ Transwoman
3. Have you taken transgender hormone therapy in the past: ☐ No ☐ Yes:
   - ☐ Medically supervised by _____
   - ☐ Unsupervised: list name of these hormones and their source (if known) _____
   - ☐ Herbal: (circle one) red clover, black cohosh/snakeroot, sage, DHEA, _____
4. Have you had transgender surgery: ☐ No ☐ Yes: When? _____
5. Do you intend on having transgender surgery? ☐ No ☐ Yes: When? _____
6. Are you doing something to prevent pregnancy? ☐ No ☐ Yes: _____ ☐ Not Applicable
7. Please list all of your current treating physicians and/or therapists:

Name	Specialty	Phone

Name Signature Date

OHIO DEPARTMENT OF PUBLIC SAFETY
BUREAU OF MOTOR VEHICLES

DECLARATION OF GENDER CHANGE

INSTRUCTIONS

The purpose of this form is to allow an individual, under the guidance and direction of a qualified and licensed professional, to change their gender designation.

All records of the Ohio Department of Public Safety or Bureau of Motor Vehicles relating to the physical or mental condition of any person are confidential and are not open to public record.

Send completed form to:

Ohio Department of Public Safety
Bureau of Motor Vehicles
Attn: License Control
P.O. Box 16784
Columbus, Ohio 43216-6784

Phone: (844) 644-6268
Fax: (614) 752-7306

Please allow 7 - 10 days for processing. The applicant will be notified in writing if the gender change is approved, and will receive documentation that may be presented to any local License Bureau agency.

OHIO DEPARTMENT OF PUBLIC SAFETY
BUREAU OF MOTOR VEHICLES

DECLARATION OF GENDER CHANGE

TO BE COMPLETED BY APPLICANT (Please type or print in ink.)

APPLICANT'S LEGAL LAST NAME		FIRST NAME		MI
RESIDENTIAL ADDRESS		CITY	STATE	ZIP CODE
DRIVER LICENSE OR ID NUMBER	DATE OF BIRTH	TELEPHONE NUMBER	MY GENDER IDENTITY IS	
		( ) -	☐ MALE ☐ FEMALE	

I certify that this request for gender designation is for the purposes of ensuring my driver's license/identification card accurately reflects my gender identity and is not for any fraudulent or other unlawful purpose. I certify under penalty of perjury that all information on this form is true and correct.

APPLICANT'S SIGNATURE	DATE SIGNED
X	

RELEASE OF INFORMATION

I hereby authorize my licensed professional to release the information below to the Ohio Bureau of Motor Vehicles for the purposes of obtaining a driver license or an identification card under my identified gender. _____ (Applicant's Initials)

LICENSED PROFESSIONAL'S STATEMENT

To be completed by a physician, psychologist, therapist, nurse practitioner, or social worker who is licensed to practice in the United States that certifies the gender identity of the applicant.

☑ PHYSICIAN ☐ NURSE PRACTITIONER ☐ PSYCHOLOGIST ☐ THERAPIST ☐ SOCIAL WORKER

LICENSED PROFESSIONAL'S LAST NAME	FIRST NAME	TELEPHONE NUMBER	
Moosa	Mahmood	(419) 724 - 0004	
PROFESSIONAL LICENSE / CERTIFICATE NUMBER	ISSUING STATE	NAME OF HOSPITAL OR MEDICAL CLINIC	
35067199	Ohio	Endocrine Specialists, PC	
STREET ADDRESS	CITY	STATE	ZIP CODE
6855 Spring Valley Drive STE 150	Holland	OH	43528

MY PROFESSIONAL OPINION IS THAT THE APPLICANT'S GENDER IDENTITY IS ☐ MALE ☐ FEMALE

I certify that my practice includes the treatment and counseling of persons with gender identity concerns, including the applicant named above, who is my patient. I certify under the penalty of perjury that all information on this form is true and correct.

SIGNATURE OF LICENSED PROFESSIONAL	DATE SIGNED
X	

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Letter Certifying Gender Change

Date: _____

To Whom It May Concern:

This is to certify

that _____, is under my medical care for gender transition, and has had appropriate clinical treatment for gender transition to the new gender of:

☐ male ☐ female.

This includes, but is not limited to, confirmed documentation stating this person has undergone appropriate mental and emotional counseling regarding their transition, and routine screening of pertinent endocrine conditions.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

Name of Physician: Mahmood Moosa, MD Signature of Physician:

Ohio Medical License Number: 35-06-7199 (Expiration Date: 7/01/2022)
Michigan Medical License Number: 4301081240 (Expiration Date: 1/31/2022)

Endocrine Specialists, PC
Email: *Call@EndoMDs.com* ***Phone:*** *734-682-5243* ***OR*** *419-724-0004* ***Fax:*** *888-677-1987*

CONSENT FOR TESTOSTERONE FOR TRANSMEN

You want to take testosterone to masculinize your body. Before taking it, there are several things you need to know about. They are the possible advantages, disadvantages, risks, warning signs, and alternatives. We have listed them here for you. It's important that you understand all of this information before you start. We are happy to answer any questions you have.

What is testosterone?
It is the sex hormone that makes certain features appear typically male. It builds muscle and causes the development of facial hair and a deeper voice.

How is testosterone taken?
It is usually injected every one to four weeks. It is not used as a pill because the body may not absorb it properly. And it may cause liver problems. Some people use skin creams and patches, but they tend to be more expensive.

The doses used for injection differ from product to product and from patient to patient. They may range from 100 to 400mg. The injections are made in a large muscle to slow the release of the hormone. But there may be unwanted swings in hormone levels. You may control the swings by changing how often the dose is given, how much of a dose is given, or by switching to a cream or a patch.

BENEFITS	RISKS
▪ appearing more like a man o bigger clitoris* o coarser skin o lower voice * o more body hair* o more facial hair* o more muscle mass o more strength o no more menstrual periods ▪ more physical energy ▪ more sex drive ▪ protection against bone thinning (osteoporosis) *These are permanent changes.	▪ acne (may permanently scar) ▪ blood clots (thrombophlebitis) ▪ emotional changes — for example, more aggression ▪ headache ▪ high blood pressure (hypertension) ▪ increased red-blood-cell count ▪ infertility ▪ inflamed liver ▪ interaction with drugs for diabetes and blood thinning — for example Coumadin and Warfarin ▪ male pattern baldness ▪ more abdominal fat — redistributed to a male shape* ▪ more risk of heart disease ▪ swelling of hands, feet, and legs ▪ weight gain

Warning — Who should not take testosterone?
It should *not* be used by anyone who is pregnant or has uncontrolled coronary artery disease.

It should be used with caution and only after a full discussion of risks by anyone who
- has acne
- has a family history of heart disease or breast cancer
- has had a blood clot

- has high levels of cholesterol
- has liver disease
- has a high red-blood-cell count
- is obese
- smokes cigarettes

Periodic blood tests to check on the effects of the hormone will be needed. Routine breast exams and pelvic exams with Pap tests should be continued, when applicable.

Please initial and date each statement on this form to show that you understand the benefits, risks, and changes that may occur from taking testosterone.

Masculinizing

_____ I know that testosterone may be prescribed to make me appear less like a woman and more like a man.

_____ I know it can take several months or longer for the effects to become noticeable. I know that no one can predict how fast – or how much – change will happen. I know that the changes may not be complete for two to five years after I start.

_____ I know that the following changes are likely and permanent even if I stop taking testosterone:
- bigger clitoris — typically about half an inch to a little more than an inch
- deeper voice
- gradual growth of mustache and beard
- hair loss at the temples and crown of the head — possibility of being completely bald
- more, thicker, and coarser hairs on abdomen, arms, back, chest, and legs

_____ I know that the following changes are usually not permanent — they are likely to go away if I stop taking testosterone:
- acne (many permanently scar)
- menstrual periods typically stop one to six months after starting
- more abdominal fat – redistributed to a male shape: decreased on buttocks, hips, and thighs; increased in abdomen – changing from ‑pear shape‖ to ‑apple shape‖
- more muscle mass and strength
- more sex drive
- vaginal dryness

_____ I know that the effects of testosterone on fertility are unknown. I have been told that I may or may not be able to get pregnant even if I stop taking testosterone. I know that I might still get pregnant even after testosterone stops my menstrual periods. I know about my birth control options (if applicable). And I know that I can’t take testosterone if I am pregnant.

_____ I know that some aspects of my body will not be changed:
- Losing some fat may make my breasts appear slightly smaller, but they will not shrink very much.
- Although my voice will deepen, other aspects of the way I speak may not sound manlier.

_____ I know that there are other treatments that may be helpful to make my breasts smaller or my speech manlier. If I have concerns, I know you can give me referrals to help me explore treatment options.

Risks of Testosterone

_____ I know the medical effects and the safety of testosterone are not completely known. There may be long-term risks that are not yet known.

_____ I know not to take more testosterone than prescribed. I know it increases health risks. I know that taking more than I am prescribed won't make changes happen more quickly or more significantly. I know my body can convert extra testosterone into estrogen, and that can slow down or stop my appearing manlier.

_____ I know that testosterone can cause changes that increase my risk of heart disease. I know these changes include having

- less good cholesterol (HDL) that may protect against heart disease and more bad cholesterol (LDL) that may increase the risk of heart disease
- higher blood pressure
- more deposits of fat around my internal organs

_____ I know that my risk of heart disease is higher if people in my family have had heart disease, if I am overweight, or if I smoke.

_____ I know that I should have periodic heart-health checkups for as long as I take testosterone. I know that means I must watch my weight and cholesterol levels and have them checked by my clinician.

_____ I know testosterone can damage the liver and possibly lead to liver disease. I know I should be checked for possible liver damage for as long as I take testosterone.

_____ I know testosterone can increase my red blood cells and hemoglobin. I know that the increase is usually only to what is normal for a man. I know that would have no health risks. But I also know that a higher increase can cause problems that can be life- threatening. These problems include stroke and heart attack. That's why I know I need to have periodic blood checks for as long as I take testosterone.
about my sex life to learn the best ways to prevent and check for infections.

_____ I know that testosterone can give me headaches or migraines. I know that it's best to talk with my clinician if I get them a lot or if the pain is unusually severe.

_____ I know that testosterone can cause emotional changes. For example, I could become more irritable, frustrated, or angry. I know that my clinician can help me find resources to explore and cope with these changes.

_____ I know that testosterone causes changes that other people will notice. Some transgender people have experienced harassment, discrimination, and violence because of this. Others have lost the support of loved ones. I know my clinician can help me find advocacy and support resources.

Prevention of Medical Complications

_____ I agree to take testosterone as prescribed. And I agree to tell my clinician if I have any problems or am unhappy with the treatment.

_____ I know that the dose and type of medication that's prescribed for me may not be the same as someone else's.

_____ I know I need periodic physical exams and blood tests to check for any side effects.

_____ I know testosterone can interact with other drugs and medicines. These include alcohol, diet supplements, herbs, other hormones, and street drugs. This kind of interaction can cause complications. I know that I need to prevent complications because they can be life-threatening. That's why I need to be honest with my clinician about whatever else I take. I also know that I will continue to get medical care here no matter what I share about what I take.

_____ I know that it can be risky for anyone with certain conditions to take testosterone. I agree to be evaluated if my clinician thinks I may have one of them. Then we will decide if it's a good idea to start or continue using testosterone.

_____ I know that using testosterone to appear manlier is an off-label use. I know this means it is not approved by the government. I know that the medicine and dose that is recommended for me is based on the judgment and experience of the health care provider.

_____ I know that I can choose to stop taking testosterone at any time. I know that if I decide to do that, I should do it with the help of my clinician. This will help me make sure there are no negative reactions. I also know my clinician may suggest that I cut the dose or stop taking it at all if certain conditions develop. This may happen if the side effects are severe or there are health risks that can't be controlled.

_____ I know that there are alternatives to using testosterone to help me appear manlier. If I am interested in alternatives to testosterone therapy, I will talk to my clinician at Endocrine Specialists, PC about my options.

_____ I know that in addition to getting endocrine care at Endocrine Specialists, PC who prescribe me hormones and other medications to help me appear manlier, I need to seek care from a primary care physician who is experienced with transgender primary care to take care of general medical problems, like flu, help coordinate the various medical services I receive from various specialists, and screen for important things like cancer whenever necessary.

My signature below confirms that

- My health care provider has talked with me about
  1. the benefits and risks of taking testosterone
  2. the possible or likely consequences of hormone therapy
  3. alternative treatment options
- I understand the risks that may be involved.
- I know that the information in this form includes the known effects and risks. I also know that there may be unknown long-term effects or risks.
- I have had enough opportunity to discuss treatment options with my clinician.
- All of my questions have been answered to my satisfaction.
- I believe I know enough to give informed consent to take, refuse, or postpone testosterone therapy.
- I am 18 years old or older.

Based on all this information:

_____ I **WANT** to begin taking testosterone. _____ I do **NOT** want to begin taking testosterone.

_____ _____
Transperson's signature Date

_____ _____
Prescribing clinician's signature Date

Your health is important to us. If you have any questions or concerns please call us at 734-682-5243 OR 419-724-0004. We will be happy to help you.

Endocrine Specialists, PC

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Transgender Medical FAQ

Q: Do I need a **letter** from a licensed mental health professional to start transgender hormones?

A: **Yes.** Although we do not require a referral letter before seeing you initially, in order to **prescribe hormone therapy,** we need a **letter** from a qualified mental health professional that states you are ready for that.

Q: Do I need a **primary care physician**?

A: **Yes.** In addition to hormones and other medications that we prescribe for you at our clinic, you need a primary care physician to take care of general medical problems, like the flu. They can also help to coordinate the various medical services you receive from any other specialists, and screen for important things like cancer, whenever necessary.

Q: Do all transgender people need **surgery**?

A: No. Some transgender people have no desire to pursue surgeries or medical intervention. Many desire only medical intervention. Others add surgery.

Q: Do I have to sign a **consent** before receiving transgender medical therapy?

A: **Yes.** In addition to the general consent for treatment, there is another consent form that you need to sign that particularly goes over different aspects of transgender medical therapy.

Q: **How frequently** do we check hormone blood level on hormone therapy?

A: This varies based on where the hormone levels are throughout treatment, but generally every month until a stable or consistent level of hormones is achieved. Visits would then change to every 3-6 months, per the individual's need.

Q: Are all medical services for transgender care **covered by insurance**?

A: **Some.** As is the case with all medical care matters, each insurance company covers a particular set of services. We recommend that you check with your insurance on whether they cover a particular service, how much is your copay/coinsurance, and whether or not you will be able to take care of your out-of-pocket costs, before you physically receive that service.

Q: Do we have a **preference for certain types of medications**?

A: **No.** We take into consideration several factors, e.g. your personal preference, appropriateness to your medical condition, insurance coverage, cost, market availability, etc.

Q: Do I need to **change my gender and name with the authorities** before starting transgender medical therapy?

A: **No.** However, **we recommend** you start working on that soon. Changing your gender on your ID is particularly helpful, as it will ensure that once you've registered your gender at the lab/hospital/insurance company, you can receive the proper services, and your lab test results are reported in a way that is consistent with your desired gender. We have a form from Ohio BMV that we can sign to help you change your gender on your Ohio driver's license.

- My signature below indicates that I understand and accept the above-mentioned information, and that I want to start/continue transgender hormone therapy.

Name Signature Date

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Masculinizing Medical Therapy Expected Results

1. Most physical changes occur over 2 years.
2. Amount of changes and exact timeline are highly variable, partly dependent on dose, route of administration, and medications used, which are selected in accordance with the transperson's:
    a. Specific medical goals (e.g., changes in gender-role expression, plans for sex reassignment)
    b. Medical risk profile

Masculinizing Medical Therapy Effect	**Onset (a)**	**Max (a)**
Skin oiliness/acne	1-6 M	1-2 Y
Facial/body hair growth	6-12 M	4 -5 Y
Scalp hair loss	6-12 M (b)	Variable
Increased muscle mass/strength	6-12 M	2-5 Y (c)
Fat redistribution	1-6 M	2-5 Y
Cessation of menses	2-6 M	
Clitoral enlargement	3-6 M	1-2 Y
Vaginal atrophy	3-6 M	1-2 Y
Deepening of voice	6 -12 M	1-2 Y

a Estimates represent published and unpublished clinical observations.
b Highly dependent on age and inheritance; may be minimal.
c Significantly dependent on amount of exercise.

- My signature below indicates that I understand and accept the above-mentioned expectations, and that I want to start/continue transgender hormone therapy.

Name _____ signature _____ Date _____