

1 Provide your personal information

Last name: _____

First name: _____ Middle name: _____

Address: _____

Postal code: _____

Phone number: _____ Date of birth (yyyy/mm/dd): _____

MSI Health Card #: _____ Expiry Date (yyyy/mm/dd): _____

Email address _____

2 Complete Patient Declaration

I am 18 years or older Yes NoI am a permanent resident of Nova Scotia Yes NoI am registered with Medical Services Insurance (MSI) in Nova Scotia and possess a valid MSI Health Card Yes NoMy physician/specialist/ WPATH trained health professional has explained the risks and complications associated with SRS Yes NoI understand that hysterectomy and oophorectomy for the purpose for SRS are only publically funded if performed in NS Yes NoI understand that mastectomy, phalloplasty, metoidioplasty, penectomy, orchiectomy and vaginoplasty for the purpose of SRS are only publically funded if performed in the Clinique de Chirurgie, Montreal, Quebec and pre-approved by MSI Yes No

I understand that there is no public funding available for:

- SRS services outside of Canada; Yes No
- Procedures not deemed medically necessary, including but not limited to, facial feminization, liposuction, tracheal shave, voice pitch surgery and breast augmentation Yes No
- SRS services received without prior approval from MSI Yes No
- Any services which are not insured by MSI Yes No
- Any take-home medications, equipment, meals and other personal expenses Yes No

I have read and understand the Department of Health and Wellness' Out of Province Travel and Accommodation Assistance Guidelines (if requesting approval for mastectomy, phalloplasty, metoidioplasty, penectomy, orchiectomy and vaginoplasty) Yes No

3 Sign the certification and consent—Patient

I **certify** that the information given on this form is complete and accurate.

I understand that my personal health information collected on this form and the attached supporting documents will only be used to process my request and will not be disclosed without my consent unless required by law.

Name (please print): _____

Signature: _____ Date: _____

4 Complete Physician/ Specialist/ WPATH Trained Health Professional Declaration

I have verified that the patient meets all general criteria for SRS:

- Patient is 18 years or older Yes No
- Patient is a permanent resident of Nova Scotia Yes No
- Patient is registered with MSI in Nova Scotia and possesses a valid MSI Health Card. Yes No

PRIMARY CLINICAL CRITERIA

I have verified that the patient has:

- Persistent, well-documented gender dysphoria diagnosis Yes No
- Capacity to make a fully informed decision and to consent for treatment: Yes No
 - Understands the procedure/s
 - Understands associated risk/s and complications
 - Has an aftercare / follow-up plan
- reasonably well controlled medical or mental health concerns, if they are present Yes No

SPECIFIC CLINICAL CRITERIA

Breast Surgery

Mastectomy

- The patient has one referral letter signed by a specialist (e.g. general surgeon, psychiatrist, endocrinologist) recommending surgery. Yes No
- hormone therapy is not a pre-requisite

Genital Surgery

Removal (ectomy): Oophorectomy, Hysterectomy, Penectomy, Orchiectomy

- The patient has one referral letter signed by one specialist (e.g. general surgeon, psychiatrist, endocrinologist) AND one WPATH trained health professional (such as a family physician or psychologist) recommending surgery. Yes No
- 12 continuous months of hormone therapy as appropriate to the patient's gender roles (unless there is medical contradiction, or inability / unwillingness to undergo hormone therapy). Yes No

Reconstruction (plasty): Phalloplasty, Metoidioplasty, Vaginoplasty

- The patient has one referral letter signed by one specialist (e.g. general surgeon, psychiatrist, endocrinologist) AND one WPATH trained health professional (such as a family physician or psychologist) recommending surgery. Yes No
- 12 continuous months of hormone therapy as appropriate to the patient's gender roles (unless there is medical contradiction, or inability / unwillingness to undergo hormone therapy) Yes No
- 12 continuous months of living in a gender role that is congruent with their gender identity Yes No

ADDITIONAL CLINICAL CRITERIA

- The patient is physically fit and has no significant physical health problems that would contraindicate or complicate the proposed surgery Yes No
- The patient is psychologically prepared for surgery Yes No
- The patient has realistic goals and expectations of the surgery Yes No
- The patient is informed of and understands any alternative procedures Yes No
- The patient has an adequate support network, a stable lifestyle and the gender identity of the individual Yes No

- has remained stable over time Yes No
- The patient has engaged in a responsible way with the assessment/treatment process Yes No

5 Inform patient of Out of Province Travel and Accommodation Assistance Guidelines, if applicable

I have reviewed the Department of Health and Wellness' Out of Province Travel and Accommodation Assistance Guidelines with the patient Yes No N/A

6 Attach supporting documents, if applicable

Required attachments:

- Patient case history to be completed by the submitting Nova Scotia physician/specialist/WPATH trained health professional (Including WPATH assessment and diagnosis of gender dysphoria) Attached Yes No
- Consultation report from the second Nova Scotia physician/specialist/ WPATH trained health professional supporting the diagnosis and recommendation for SRS (for genital surgeries) Attached Yes No
- Consultation report from Nova Scotia physician/specialist/ WPATH trained health professional indicating the patient is physically and psychologically fit to receive SRS Attached Yes No
- Letter from the patient's Nova Scotia physician/specialist/ WPATH trained health professional confirming that follow-up outpatient support will be provided in NS Attached Yes No

Required attachments, if applicable:

- Consultation report from a Nova Scotia physician/specialist/ WPATH trained health professional who has been supervising the hormonal aspects of treatment (if applicable) Attached Yes No
- Operative reports on the patient's prior SRS surgeries and/or treatment (if applicable). Attached Yes No

6 Sign the certification and consent—Physician/ Specialist/ WPATH trained health professional

I **certify** that the information given on this form is complete and accurate.

Name (please print): _____

Signature: _____ Date: _____

6 Return the form and attachments to:

Medical Services Insurance (MSI)
230 Brownlow Ave
Dartmouth, NS, B3J 2S1

Questions? Call 1-800-563-8880

<p>For Staff Use Only</p> <p>Authorized signature: _____</p> <p>Date: _____</p>
--