Gender Affirming Surgery Application
Health and Wellness

NOVA SCOTIA

Personal Information

Last name: _____ Preferred name: _____

First name: _____ Middle name(s): _____

Pronoun(s): _____

Mailing address: _____

Postal code _____

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

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

Email address: _____

Patient Declaration

I will be 18 years or older at the time of surgery.
(An exemption to the age requirement for chest surgeries can be requested by individual, beginning at 16-years of age, through their health care provider. See the 'Physician/NP/Specialist Declaration' section below) . . . . . ❑ Yes ❑ No

I am a permanent resident of Nova Scotia. . . . . ❑ Yes ❑ No

My Physician, Nurse Practitioner (NP), Specialist or Health Care Professional (HCP) has explained the risks and complications associated with Gender Affirming Surgery (GAS). . . . . ❑ Yes ❑ No

I understand that all publicly funded GAS must be approved by Medical Services Insurance (MSI) prior to the procedure, this includes procedures to be performed at a pre-approved out-of-province facility. The location where the procedure is performed will be determined on a case-by-case basis and will depend upon the nature and extent of the procedure and the availability of infrastructure and clinical expertise. . . . . ❑ Yes ❑ No

1. The following procedures are publicly funded and available to be performed in Nova Scotia and at the Centre Métropolitain de Chirurgie-GrS, Montreal, Quebec (a pre-approved out-of-province partner facility):
   - » Orchiectomy
   - » Penectomy
   - » Breast Augmentation
   - » Breast Reduction
   - » Mastectomy/Chest Masculinization
   - » Hysterectomy
   - » Oophorectomy

2. The following procedures are publicly funded and only available at the GrS clinic, Montréal:
   - » Phalloplasty
   - » Metoidioplasty
   - » Vaginoplasty

I understand that there is no public funding available for:

- GAS services outside of Canada . . . . . ❑ Yes ❑ No
- Procedures sometimes performed with GAS, such as, Facial Feminization, Liposuction, Tracheal Shave, Voice Pitch Surgery . . . . . ❑ Yes ❑ No
- GAS services received outside Nova Scotia 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 (DHW) Out-of-Province Travel and Accommodation Assistance Guidelines (if requesting approval for GAS to be performed at the GrS clinic, Montréal). . . . . ❑ Yes ❑ No

Certification and Patient Consent

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 the Nova Scotia Personal Health Information Act (PHIA).
- The personal health information indicated on this application will be disclosed to the Nova Scotia Health Care Professional(s) and/or to the Out-of-Province provider(s) responsible for my care (if approved for publicly funded GAS to be performed at GrS Clinic, Montreal), and may be used for future correspondence related to this application.

Legal name: _____ Date: _____ Signature: _____

Physician/NP/Specialist Declaration

I have verified that the patient meets the following criteria for GAS:

- Patient is aware surgery cannot be performed until they are 18 years or older (If an adolescent, who is 16-years of age or older is requesting an exemption for chest surgery, they must demonstrate the emotional and cognitive maturity required to provide informed consent as assessed by the multidisciplinary team of relevant mental health and medical professionals. The health care provider must check the "exemption requested" box and provide a letter attached to this application explaining the rationale for exemption for MSI to send to DHW for approval). . . . . ❑ Yes ❑ No
- Exemption requested . . . . . ❑ Yes ❑ No

Clinical Eligibility Criteria

I have verified that the patient:

- Has marked and sustained gender dysphoria and other possible causes of apparent gender dysphoria have been identified and excluded. . . . . ❑ Yes ❑ No
- Has the capacity to make a fully informed decision and to consent for the specific hormone treatment or surgical intervention including the following criteria:
  - » Understands the procedure(s) and any alternative procedure(s)
  - » Understands risk(s)/benefits and complications associated with the treatment or not getting the treatment
  - » Has an aftercare/follow-up plan . . . . . ❑ Yes ❑ No
- Has sufficiently well controlled medical or mental health concerns if they are present that could negatively impact the outcome or contraindicate GAS. . . ❑ Yes ❑ No
- Is stable on their gender affirming hormonal treatment regime, which may include at least six (6) months of hormone treatment for genital surgeries for adults, and 12 months of hormone treatment for adolescents for breast augmentation (or longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated). Hormone therapy is not a criteria to be eligible for chest surgeries, except breast augmentation. . . . . ❑ Yes ❑ No
- Understands the effect of gender affirming hormone treatment or surgical intervention on reproduction and have explored reproductive options. . . . . ❑ Yes ❑ No

Surgical Eligibility Criteria

Chest masculinization/mastectomy/breast reduction/breast augmentation.
Removal (ectomy): oophorectomy, hysterectomy, penectomy, orchidectomy.
Reconstruction (plasty): phalloplasty, metoidioplasty, vaginoplasty.

I have verified that in addition to clinical eligibility criteria the patient has:

- GAS application signed by a NS Physician, NP, or Specialist. . . . . ❑ Yes ❑ No
- One psychosocial assessment letter (required by WPATH and GrS clinic), signed by a healthcare professional who has the required WPATH credentials (as outlined in Appendix A) and training in culturally competent trans care (it can be the same signatory as for the application itself). . . . . ❑ Yes ❑ No
- Letter from Family Physician or NP, confirming post-operative care (for surgeries done out-of-province). . . . . ❑ Yes ❑ No
- Letter from a physician, nurse practitioner or specialist monitoring hormone therapy (if applicable and not covered by one of the above letters). . . . . ❑ Yes ❑ No
- Understanding of the effect of gender affirming hormone treatment or surgical intervention on reproduction and have explored reproductive options. . . ❑ Yes ❑ No

I certify that I meet the credentials as outlined in Appendix A. . . . . ❑ Yes ❑ No

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

Certification And Consent Physician/NP/Specialist

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

Name: _____ Professional designation: _____

Date: _____ Signature: _____

Return the Form and Attachments to:
Medical Services Insurance (MSI)
230 Brownlow Ave.
Dartmouth, NS, B3J 2S1
Fax: (902) 490-2275

Questions on out of Province coverage?
Call 1-800-563-8880

For Staff Use Only

Date: _____

_____
Authorized Signature

Surgical and Hormone Treatment Readiness Assessor Credentials/Certification and Recommendation

The Nova Scotia Department of Health and Wellness requires qualified Health Care Professionals (HCP) assessing, diagnosing, and referring Transgender and Gender Diverse (TGD) people for Gender Affirming Care including Gender Affirming Surgeries, to have the following credentials:

- Licensed by their statutory body and hold, at a minimum, a master's degree or equivalent training in aclinical field relevant to this role and granted by a nationally accredited statutory institution.
- Competency in using the Diagnostic Statistical Manual of Mental Disorders and/or the International Classification of Diseases for diagnostic purposes.
- Ability to assess capacity to consent for treatment.
- Ability to recognize and diagnose/assess co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity.
- Experience and qualifications to assess clinical aspects of gender dysphoria, incongruence, and diversity.
- Continuing education in health care relating to gender dysphoria, incongruence, and diversity.[1]
- Knowledge about TGD identities and expression.
- WPATH informed and knowledgeable and experienced in providing culturally competent and safe transcare e.g. have attended any symposiums, conferences or workshops/training such as the Trans Health symposium, CPATH/ WPATH or prideHealth conferences, or have taken relevant mainpro+ courses/training.

I certify that I meet the above credentials and the information given on this form is complete and accurate.

Name: _____ Professional designation: _____

Date: _____ Signature: _____

I recommend this client for Gender Affirming Hormone Treatment/Puberty Blockers[2] ❑ Yes ❑ No

I recommend this client for Gender Affirming Surgery ❑ Yes ❑ No

Patient name (as it appears on the MSI card): _____

Patient's MSI number: _____

1 Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 (tandfonline.com)

2 For children and adolescents as defined in the GAC policy