NOVA SCOTIA
Health & Wellness

Gender Affirming Surgery Application

PERSONAL INFORMATION

Last Name_____

Preferred Name_____ Pronoun(s): _____

First name: _____ Middle name(s): _____

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 exception to the age requirement can be requested for chest surgeries by individuals at 16 years of age through their health care provider. Please 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 Provider (HCP) has explained the risks and complications associated with Gender Affirming Surgery (GAS) ☐ Yes ☐ No

I understand that out of province GAS surgical procedures are publicly funded only when they are pre-approved by Medical Services Insurance (MSI). 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 surgery and the availability of surgical expertise. ☐ Yes ☐ No

1. The following procedures are available in Nova Scotia and only insured if performed in this province:
    a. Hysterectomy
    b. Oophorectomy

2. The following procedures are available in both Nova Scotia and at the GrS clinic, Montréal and may be insured at both locations:
    a. Orchiectomy
    b. Penectomy
    c. Breast Augmentation
    d. Breast Reduction
    e. Mastectomy/Chest Masculinization

3. The following procedures are only available at the GrS clinic, Montréal and are only insured if performed there:
    a. Phalloplasty
    b. Metoidioplasty
    c. 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 NS 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 ☐ N/A

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 NS *Personal Health Information Act (PHIA)*

Legal Name (please print): _____

Signature: _____ Date: _____

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 ☐ Yes ☐ No

(An exception to this requirement can be made by the health care provider to allow chest surgeries to be performed at 16 years of age. Rationale for exception must be provided in a letter attached to this application and must be provided to DHW for approval) ☐ Exception requested

Primary Clinical Criteria

I have verified that the patient has:

- Persistent, well-documented gender dysphoria ☐ Yes ☐ No
- Capacity to make a fully informed decision and to consent for treatment**,** including the following criteria: ☐ Yes ☐ No
  - Understands the procedure(s) and any alternative 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 and would not contraindicate GAS ☐ Yes ☐ No

Surgical Criteria

CHEST SURGERY
Chest Masculinization / Mastectomy / Breast Reduction
In addition to primary clinical 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 health care provider with clinical competencies outlined in the World Professional Association for Transgender Care (WPATH) Standards of Care (SoC)[1] ***(it can be the Physician/NP/Specialist who signs the application)*** ☐ Yes ☐ No

- Letter from Family Physician or NP, confirming post-operative care ***(for surgeries done out of province)*** ☐ Yes ☐ No

Hormone therapy is not a pre-requisite

Breast Augmentation
In addition to primary clinical 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 health care provider with clinical competencies outlined in the WPATH - SoC ***(it can be the Physician/NP/Specialist who signs the application)*** ☐ Yes ☐ No
- Letter from Family Physician or NP, confirming post-operative care ***(for surgeries done out of province)*** ☐ Yes ☐ No
- Minimum 12 months of hormone therapy (recommended by WPATH) with breast growth less than or equal to Tanner stage 2 ***(unless there is medial contradiction, or inability / unwillingness to undergo hormone therapy)*** ☐ Yes ☐ No

GENITAL SURGERY
Removal (ectomy): Oophorectomy, Hysterectomy, Penectomy, Orchiectomy or Reconstruction (plasty): Phalloplasty, Metoidioplasty, Vaginoplasty
In addition to primary clinical criteria the patient has:

- GAS application signed by a NS Physician, NP or Specialist ☐ Yes ☐ No
- Two psychosocial assessment letters (required by WPATH and GrS clinic) signed by health care providers with clinical competencies outlined in the WPATH - SoC ***(one of the letters can be provided by the NS Physician /NP/ Specialist who signs the application)*** ☐ Yes ☐ No
- A letter from Family Physician or NP, confirming post-operative care ***(for surgeries done out of province)*** ☐ Yes ☐ No
- A letter from Physician, NP or Specialist monitoring hormone therapy *(if not covered by one of the above letters)* ☐ Yes ☐ No
- 12 continuous months of hormone therapy as appropriate to the patient's gender goals ***(unless there is medial contradiction, or inability / unwillingness to undergo hormone therapy)*** ☐ Yes ☐ No
- Been living for 12 continuous months in a gender role that is congruent with their gender identity *(WPATH recommendation for reconstruction procedures)* ☐ Yes ☐ No

[1] SOC V7_English.pdf (wpath.org) -Page 22

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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 (please print): _____

Signature: _____ Date: _____

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

Authorized signature:

Date: