NOVA SCOTIA

Gender Affirming Surgery
Approval Request Form / Application

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: _____

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2 Complete patient declaration

I will be 18 years or older at the time of surgery ☐ Yes ☐ No

I am a permanent resident of Nova Scotia (NS) ☐ Yes ☐ No

I am registered with Medical Services Insurance (MSI) in NS and possess a valid MSI Health Card ☐ 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 Hysterectomy and Oophorectomy for the purpose of GAS are only publicly funded if performed in NS. Orchiectomy and Breast Augmentation for the purpose of GAS can be performed in NS if requested as an isolated procedure and can also be done in Montreal as part of complete Male to Female (MtF) transition. Chest masculinization /mastectomy for the purpose of GAS can be performed in NS if requested as an isolated procedure and can be done in Montreal as part of complete Female to Male (FtM) transition. ☐ Yes ☐ No

I understand that Chest Masculinization / Mastectomy, Phalloplasty, Metoidioplasty, Breast Augmentation, Penectomy, Orchiectomy and Vaginoplasty for the purpose of GAS are publicly funded if performed at the Centre Métropolitain de Chirurgie, Montreal, Quebec and pre-approved by MSI., Chest Masculinization / Mastectomy, Orchiectomy and Breast Augmentation for the purposes of GAS are also publicly funded if performed in NS, as isolated procedures. ☐ Yes ☐ No

I understand that there is no public funding available for:

- GAS services outside of Canada; ☐ Yes ☐ No
- GAS procedures not deemed medically necessary, such as, Facial Feminization, Liposuction, Tracheal Shave,and Voice Pitch Surgery. ☐ Yes ☐ No
- GAS 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 (DHW) Out of Province Travel and Accommodation Assistance Guidelines (if requesting approval for Chest Masculinization / Mastectomy, Phalloplasty, Metoidioplasty, Breast Augmentation, Penectomy, Orchiectomy and Vaginoplasty for the purpose of GAS performed at the Centre Métropolitain de Chirurgie, Montreal, Quebec)

☐ 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 the NS *Personal Health Information Act (PHIA)*

Name (please print): _____

Signature: _____ Date: _____

4 Complete Physician/ NP/ Specialist declaration

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

- Patient is aware surgery cannot be performed until they are 18 years or older ☐ Yes ☐ No
- Patient is a permanent resident of NS ☐ Yes ☐ No
- Patient is registered with MSI in NS and possesses a valid MSI Health Card. ☐ Yes ☐ No

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
    - 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

Additional Criteria

- The patient 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 engaged in a responsible way with the assessment/treatment process ☐ Yes ☐ No

Surgical Criteria

CHEST SURGERY
Chest Masculinization / Mastectomy

In addition to the approval request form / application signed by a NS Physician or NP, the patient has:

- One referral letter signed by a NS Specialist (e.g. general or any other surgeon, psychiatrist, endocrinologist) recommending surgery ☐ Yes ☐ No

- One referral letter (based on psychosocial assessment) signed by a HCP trained in the WPATH SOC. If the referring specialist is trained in WPATH SOC, no additional support letter is required. ☐ Yes ☐ No
- Letter from Family Physician (confirming post-operative care) ☐ Yes ☐ No
- Hormone therapy is not a pre-requisite ☐ Yes ☐ No

Breast augmentation

In addition to the approval request form / application signed by a NS Physician or NP, the patient has:

- One referral letter signed by a NS Specialist (e.g. general or any other surgeon, psychiatrist, endocrinologist) recommending surgery ☐ Yes ☐ No
- One referral letter (based on psychosocial assessment) signed by a HCP trained in the WPATH SOC. If the referring specialist is trained in WPATH SOC, no additional support letter is required. ☐ Yes ☐ No
- Letter from Family Physician (confirming post-operative care) ☐ Yes ☐ No
- Had 12 continuous months of hormone therapy without satisfactory breast growth (Tanner stage ≤ 2) ☐ Yes ☐ No

GENITAL SURGERY
Removal (ectomy): Oophorectomy, Hysterectomy, Penectomy, Orchiectomy or
Reconstruction (plasty): Phalloplasty, Metoidioplasty, Vaginoplasty

In addition, to the approval request form / application signed by a NS Physician or NP the patient has:

- One referral letter signed by a NS Specialist (e.g. general or any other surgeon, psychiatrist, endocrinologist) recommending surgery ☐ Yes ☐ No
- Two referral letters (based on psychosocial assessment) signed by HCP`s trained in the WPATH SoC. If the referring specialist is trained in WPATH SoC, then only one additional referral letter is required ☐ Yes ☐ No
- A letter from Family Physician (confirming post-operative care) ☐ Yes ☐ No
- A letter from Physician supervising hormone therapy (if not covered by one of the above letters) ☐ Yes ☐ No
- Had 12 continuous months of hormone therapy as appropriate to the patient`s gender roles (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 (As per WAPATH SoC, this criterion only applies to reconstruction surgeries). ☐ 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. Sign the certification and consent—Physician/ NP/ Specialist

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

Name (please print):_____

Signature: _____ Date: _____

7 Return the form and attachments to:

Medical Services Insurance (MSI)
230 Brownlow Ave
Dartmouth, NS, B3J 2S1
Questions? Call 1-800-563-8880

For Staff Use Only

Authorized signature: _____

Date: _____