NOVA SCOTIA

Health & Wellness

Sex Reassignment Surgery Approval Request

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 Declarations

I am 18 years or older	☐ 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/specialist or health care provider (HCP) trained in World Professional Association for Transgender Health (WPATH) Standards of Care (SoC) has explained the risks and complications associated with SRS	☐ Yes ☐ No
I understand that hysterectomy and oophorectomy for the purpose of SRS are only publically funded if performed in NS	☐ Yes ☐ No
I understand that chest masculinization/mastectomy, Phalloplasty, Metoidioplasty, Penectomy, Orchiectomy and Vaginoplasty for the purpose of Sex Reassignment Surgery are only publicly funded if performed in the Centre Métropolitain de Chirurgie, Montreal, Quebec and pre-approved by MSI. However, an Orchiectomy for the purpose of SRS, is also publicly funded if performed in NS (as an isolated procedure)	☐ Yes ☐ No
I understand that there is no public funding available for:	
• SRS procedures outside of Canada	☐ Yes ☐ No
• Procedures not deemed medically necessary, such as, Facial Feminization, Liposuction, Tracheal Shave and Voice Pitch Surgery	☐ 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 Policy (if requesting approval for Chest Masculinization / 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/ HCP trained in the WPATH SoC 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 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, and: ☐ 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

Chest Surgery

Chest Masculinization / Mastectomy

- The patient has one referral letter signed by a specialist (e.g. general or any other Surgeon, Psychiatrist, Endocrinologist) recommending surgery and **one referral letter** (based on psychosocial assessment) signed by a HCP trained in the WPATH SoC) ☐ Yes ☐ No
- Hormone therapy is not a pre-requisite ☐ Yes ☐ No

Genital Surgery

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

- The patient has **one referral letter** signed by a specialist (e.g. general or any other surgeon, Psychiatrist, Endocrinologist) recommending surgery, and **two referral letters** (based on psychosocial assessment) signed by a HCP trained in the WPATH SoC. If the referring specialist is trained in WPATH SoC, then only **one additional referral letter** (based on psychosocial assessment) done by a HCP trained in the WPATH SoC is required ☐ Yes ☐ No

- 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

  Reconstruction (plasty): Phalloplasty, Metoidioplasty, Vaginoplasty

- The patient has **one referral letter** signed by a specialist (e.g. general or any other Surgeon, Psychiatrist, Endocrinologist) recommending surgery, and **two referral letters** (based on psychosocial assessment) signed by HCP trained in the WPATH SoC**.** If the referring specialist is trained in WPATH SoC, then only **one additional referral letter** (based on psychosocial assessment) done by a HCP trained in the WPATH SoC is required ☐ Yes ☐ No

- 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

- 12 continuous months of living in a gender role that is congruent with their gender identity ☐ 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

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

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

6. Attach supporting documents, if applicable

Required attachments:

- Patient case history to be completed by the submitting NS physician/specialist/ HCP trained in the WPATH SoC (Including WPATH psychosocial assessment and diagnosis of gender dysphoria) Attached ☐ Yes ☐ No

- Consultation report from a NS physician/ specialist/ HCP trained in the WPATH SoC supporting the diagnosis and recommendation for SRS (for genital surgeries) Attached ☐ Yes ☐ No

- Consultation report from NS physician/ specialist/ HCP trained in the WPATH SoC indicating the patient is physically and psychologically fit to receive SRS Attached ☐ Yes ☐ No

- Letter from the patient's NS physician/specialist/ HCP trained in the WPATH SoC confirming that post-surgical follow-up outpatient support will be provided in NS Attached ☐ Yes ☐ No

- Letter from client's family physician providing information on client's health history and confirming availability of post-operative care Attached ☐ Yes ☐ No

Required attachments, if applicable:

- Consultation report from a NS physician/specialist 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

---

7. Sign the certification and consent—Physician/ Specialist/ HCP trained in the WPATH SoC

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

Name (please print): _____

Signature: _____ Date: _____

---

8. 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: _____