on professional letterhead

[Provider Name, Credentials]
[Practice Name]
[Address, City, State, Zip code]
[Phone Number]
[Email Address]
[Date]

To Whom It May Concern:

I am writing in support of my patient, [Patient Name], who is under my care for the diagnosis of Gender Dysphoria (ICD-10 code: F64.9). I am a [licensed mental health provider/physician/ nurse practitioner] with [X] years of clinical experience, licensed in the state of [State].

[Patient Name] has been in my care since [Month, Year]. They are a [age]-year-old transgender man / non-binary transmasculine person who experiences clinically significant distress related to incongruence between their gender identity and physical appearance.

In my professional assessment, [Patient Name] meets the diagnostic criteria for Gender Dysphoria as outlined in the DSM-5-TR and WPATH Standards of Care, Version 8. We have discussed gender-affirming surgical options, and [Patient Name] has expressed a clear, consistent, and persistent desire for chest masculinization surgery (commonly known as “top surgery”) as an essential component of their gender transition.

[Patient Name] has demonstrated the capacity to make a fully informed decision and to consent for this surgery. We have reviewed the risks, benefits, and alternatives, and they have expressed an understanding of these factors.

[Patient Name] has been living in a gender role congruent with their gender identity since [Month, Year]. [Optional: They have been undergoing hormone therapy with testosterone since [Month, Year], under the supervision of [provider name].]

In my professional opinion, chest masculinization surgery is a medically necessary and appropriate intervention for alleviating [Patient Name]’s gender dysphoria. Denial or delay of this surgery is likely to result in the continuation of clinically significant distress and negative mental health outcomes.

I therefore recommend that [Patient Name] be approved for gender-affirming chest masculinization surgery. This recommendation is based on current clinical guidelines and the WPATH Standards of Care, Version 8.

If you have any questions, I can be reached at the contact information provided above.

Sincerely,

[Provider Signature]
[Provider Name, Credentials]
[License Number and State]