CLINICAL SUMMARY AND TRANSFER RECORD

FOR YOUTH WITH GENDER DYSPHORIA/GENDER INCONGRUENCE

BY THE ENDOCRINE SOCIETY

ENDOCRINETRANSITIONS.ORG

Name: _____

Preferred Name: _____

Gender Identity: _____ Pronouns: _____

Age at social transition (informed teachers/family/friends of affirmed gender): _____

Age at the initiation of sex steroid hormones: _____

Treated with GnRH analogues for pubertal blockade? ☐ YES ☐ NO

Age at the initiation of GnRH analogues: _____

Age when GnRH analogues stopped or still continuing: _____

PROBLEM LIST:

Diagnosis:	Date of Diagnosis:

HORMONE REPLACEMENT:

Name	Dose	Route	Frequency
Estradiol		• Oral • Transdermal • Intramuscular	
Testosterone		• Transdermal • Intramuscular • Subcutaneous	
Androgen Blocker • GnRH analogue • Spironolactone			

OTHER MEDICATIONS:

Name	Dose	Route	Frequency

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Name: _____ Date of Birth: ____ /____ /_____

Any complications of hormone therapy: _____

_____

_____

_____

_____

REPRODUCTIVE HEALTH:

Fertility preservation before hormonal therapy? ☐ YES ☐ NO

For trans men

History of pregnancy? ☐ YES ☐ NO

BONE HEALTH:

Date of last DXA: _____

Z-scores

Lumber Spine _____ Total Hip _____ Femoral Neck _____

Whole Body Less Head _____

History of fractures? ☐ YES ☐ NO If yes, list date(s): _____

Vitamin D deficiency? ☐ YES ☐ NO If yes, current treatment: _____

MENTAL HEALTH:

History of depression? ☐ YES ☐ NO

History of suicidality or suicide attempts? ☐ YES ☐ NO

History of Anxiety? ☐ YES ☐ NO

Name of current mental health provider: _____

METABOLIC HEALTH:

Lipid abnormalities? ☐ YES ☐ NO

Hypertension? ☐ YES ☐ NO

Other: _____

Family history of clotting: ☐ YES ☐ NO

Tobacco use? ☐ YES ☐ NO

Alcohol use? ☐ YES ☐ NO

Illicit drug use? ☐ YES ☐ NO

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Name: _____ Date of Birth:____ /____ /_____

SOCIAL HISTORY:

Living with: _____

Currently a: ☐ student ☐ working ☐ at home

Sexually active? ☐ YES ☐ NO

If yes, with: ☐ men ☐ women ☐ both

Organs used for sex (List all body parts): _____

_____

_____

_____

_____

Safer sex practices? ☐ YES ☐ NO

History of any STI or HIV? ☐ YES ☐ NO If yes, please explain: _____

_____

_____

_____

RECENT PHYSICAL EXAM FINDINGS

Date: _____

Height	
Weight	
BMI	
Blood pressure	

RECENT LABORATORY RESULTS

Name	Date	Result
Estradiol		
Total testosterone		
Hemoglobin		
Hematocrit		
AST		
ALT		
25-hydroxyvitamin D		
Total cholesterol		
Triglycerides		
LDL		
Potassium		
Creatinine		
Prolactin		

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Name: _____ Date of Birth:____ /____ /_____

SURGERIES:

Type of Surgery	Name of Surgeon	Date

CARE TEAM:

	Pediatric Provider	Adult Provider
Primary Care		
Endocrinologist		
Surgeon		
Reproductive Endocrinologist		
Mental Health Counselor		
Psychiatrist		

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