

## Policy G-51.11 Treatment of Inmates with Gender

### Consent Form for Therapy with Male Hormones

The full medical effects and safety of hormone therapy are not fully known. Potential adverse effects may include, but are not limited to:

- Increased cholesterol and/or fats in the blood
- Increased number of red blood cells (increased hemoglobin), which may cause headache, dizziness, heart attack, confusion, visual disturbances, or stroke.
- Acne
- High blood pressure
- Liver inflammation, tumors, or cancer
- Increased risk of blood clots
- Increased risk of heart disease and stroke;
- Increased or decreased sex drive and sexual functioning;
- Psychiatric symptoms such as depression and suicidal feelings; anxiety; psychosis (disorganization and loss of touch with reality), and worsening of pre-existing psychiatric illnesses.

Some side effects from hormones are irreversible and can cause death. The risks for some of the above adverse events may be INCREASED by:

- Pre-existing medical conditions
- Pre-existing psychiatric conditions
- Cigarette smoking
- Alcohol use

Irreversible body changes (potential increases with length of time on hormones) resulting from hormone therapy may include, but are not limited to:

- Deepening of voice,
- Development of facial & body hair,
- Fat redistribution,
- Genital changes (i.e. enlargement of clitoris & labia, vaginal dryness),
- Infertility,
- Male pattern baldness.

My signature below constitutes my acknowledgement of the following: The risks of hormone therapy have been explained to me.

I have read and understand the above information regarding hormone therapy.

I have had sufficient opportunity to discuss my condition and treatment with my health care providers, and all of my questions have been answered to my satisfaction.

I believe I have adequate knowledge on which to base an informed consent to the provision of hormone therapy and accept the risks involved.

I agree to have physical examinations and blood tests periodically to make sure I am not having a bad reaction to the hormones. I understand this is required to continue hormone therapy.

I understand that there are medical conditions that could make taking hormones either dangerous or damaging. I agree that if my health care providers suspect I may have one of these conditions, I will be evaluated for it before the decision to start or continue hormone therapy is made.

I understand that I can choose to stop taking hormone therapy at any time. I also understand that my provider can discontinue treatment for clinical reasons.

I am requesting and give my informed consent to the provision of hormone therapy.

\_\_\_\_\_  
Signature of Inmate

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date