

Appendix 1—Gender health program intake elements

1. Last name, First name, Middle name
2. Preferred name
3. Documentation name
4. Date of name change
5. Birth date
6. Gender pronouns
 - a. Feminine pronouns (e.g. she/her/hers)
 - b. Masculine pronouns (e.g. he/him/his)
 - c. Neutral pronouns (e.g. they/them/theirs)
 - d. No pronouns
 - e. Other
7. Sexual orientation
 - a. Lesbian
 - b. Gay
 - c. Straight
 - d. Queer
 - e. Bisexual
 - f. Other
 - g. Choose not to disclose
8. Gender identity
 - a. Female
 - b. Male
 - c. Transgender female
 - d. Transgender male
 - e. Genderqueer
 - f. Gender non-binary
 - g. Gender fluid
 - h. Other
9. Assigned/documented sex at birth
 - a. Female
 - b. Male
 - c. Intersex/DSD
10. Insurance type
 - a. PPO
 - b. HMO
 - c. Medi-Cal
 - d. Medicare
 - e. No insurance
11. Insurance status
 - a. Active
 - b. Inactive
12. Initial patient contact date
13. Initial Gender Health Program contact date
14. Phone number

15. Race
 - a. American Indian/Alaska Native
 - b. Asian/Asian American
 - c. Black/African American
 - d. Native Hawaiian/Pacific Islander
 - e. White
 - f. Other
16. Ethnicity: Hispanic or Latino Origins
 - a. Yes
 - b. No
17. Need language translation?
 - a. Yes
 - b. No
18. If yes, what language?
19. Documentation gender markers
 - a. Female
 - b. Male
 - c. Gender non-binary
20. Patient's goal/interest
 - a. Establish primary care
 - b. Hormone management
 - c. Referral for surgical services
 - d. Referral for fertility services
 - e. Referral for other health concerns
 - f. Behavioral health services
 - g. Other
21. If referral for surgical services selected:
 - a. Vaginoplasty with or without canal
 - b. Metoidioplasty
 - c. Phalloplasty
 - d. Scrotoplasty
 - e. Breast augmentation
 - f. Chest reconstruction
 - g. Facial reconstruction
 - h. Hysterectomy
 - i. Vocal surgery
 - j. Tracheal shave
 - k. Orchiectomy
 - l. Other
22. Primary care provider
 - a. Yes
 - b. No
23. Name of primary care provider

Transition history

24. When was your social transition?

25. In need of social support resources

- a. Yes
- b. No

26. Surgical transition- underwent:

- a. None
- b. Breast augmentation
- c. Orchiectomy
- d. Vaginoplasty
- e. Clitoral/labial reconstruction
- f. Facial feminization
- g. Tracheal shave
- h. Bilateral complete mastectomy
- i. Hysterectomy w/ oophorectomy
- j. Phalloplasty
- k. Urethroplasty
- l. Voice surgery
- m. Metoidioplasty
- n. Chest reconstruction
- o. Vaginectomy
- p. Scrotoplasty
- q. Other

27. Surgical transition- planned/scheduled

- a. None
- b. Breast augmentation
- c. Orchiectomy
- d. Vaginoplasty
- e. Clitoral/labial reconstruction
- f. Facial feminization
- g. Tracheal shave
- h. Bilateral complete mastectomy
- i. Hysterectomy w/ oophorectomy
- j. Phalloplasty
- k. Urethroplasty
- l. Voice surgery
- m. Metoidioplasty
- n. Chest reconstruction
- o. Vaginectomy
- p. Scrotoplasty
- q. Other

28. Would like referral for:

- a. None
- b. Breast augmentation
- c. Orchiectomy
- d. Vaginoplasty
- e. Clitoral/labial reconstruction
- f. Facial feminization

- g. Tracheal shave
 - h. Bilateral complete mastectomy
 - i. Hysterectomy w/ oophorectomy
 - j. Phalloplasty
 - k. Urethroplasty
 - l. Voice surgery
 - m. Metoidioplasty
 - n. Chest reconstruction
 - o. Vaginectomy
 - p. Scrotoplasty
 - q. Other
29. Prior psychiatric diagnoses
- a. ADHD
 - b. Anxiety
 - c. Autism spectrum disorder
 - d. Asperger syndrome
 - e. Bipolar
 - f. Depression
 - g. Eating disorder
 - h. Gender dysphoria
 - i. PTSD/Trauma
 - j. Substance use disorder
 - k. Other
30. Prior psychiatric hospitalization
- a. Yes
 - b. No
31. Prior behavioral health treatment
- a. Yes
 - b. No
32. Current behavioral health treatment
- a. Yes
 - b. No
33. Reproductive life planning- Goals
- a. Yes
 - b. No
34. Fertility preservation undergone
- a. Yes
 - b. No
35. Fertility preservation desired
- a. Yes
 - b. No
36. Chronic medical illnesses/specialist referrals may be needed
- a. Yes
 - b. No