[Date]

[Surgeon Name]
[Clinic/Hospital Name]
[Address]
[City, State, Zip Code]

RE: Gender Affirming Surgery Clearance for [Patient Full Name] (DOB: [Date of Birth])

Dear [Surgeon Name],

I am writing this letter to provide a formal psychiatric evaluation and recommendation for [Patient Name] regarding their request for [Specific Surgery Type, e.g., Vaginoplasty, Phalloplasty, Mastectomy].

I have personally evaluated [Patient Name] on [Date of Evaluation(s)]. Based on this assessment and our clinical history, I can confirm the following:

- The patient has a persistent and well-documented diagnosis of Gender Dysphoria (ICD-10 F64.0).
- The patient has the capacity to make a fully informed decision and has consented to treatment.
- The patient has reached the age of majority in this jurisdiction.
- Any significant medical or mental health concerns are currently well-controlled and stable.
- The patient has a clear understanding of the procedure, including risks, benefits, and the required post-operative recovery plan.

The patient has been living in their identified gender role for [Number] years/months and has been receiving hormone replacement therapy for [Number] years/months (if applicable). [Patient Name] expresses a strong desire for this surgery as a vital step in their transition to alleviate gender dysphoria and improve their overall psychological well-being.

I believe [Patient Name] meets the WPATH Standards of Care criteria for this procedure. I fully support their decision and provide my formal clearance for them to proceed with surgery.

If you require any further documentation or have questions, please contact me at [Phone Number] or [Email].

Sincerely,

[Signature]
[Provider Name, Degree]
[License Type and Number]
[Clinic Name]