Transgender-Gender Diverse Medicine in Youth:
Endocrine Treatment Options,
Nuances, and Challenges
A Look at Past, Present and Future
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Co Director, LHS Gender and Sexual Health Services

I have no financial disclosures. Some medications in this talk may be considered off label.

Why Am I Here?
- My Lens
- To help facilitate comprehensive care for Transgender kids
- To help with your comfort level in providing affirming care to them and their families
- To help with training in gender appropriate verbiage and understanding of the basics in transgender medicine.
Basic Terminology

- **Sex**
  Assigned, physical findings

- **Gender**
  Internal sense of maleness, femaleness

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Basic Terminology

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Gender Identity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual Development</td>
<td>Gender Expression</td>
</tr>
</tbody>
</table>

Gender:
Behavioral, cultural, and psychological characteristics associated with femaleness or maleness

Sexual Orientation:
- Enduring patterns of attraction to others
  +/- sexual behaviors; +/- affiliation with a group; DIVERSITY

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Genderbread Person

The Genderbread Person v2.1
T-Clinic Experience

Affirmed Gender

- Affirmed Female
- Affirmed Male
- Fluid

Why Transgender/NonBinary in LGBTQ?

- Recognize what is affirming for LGB community may be inclusive of T/Q folks as well
- Clustered because of SHARED EXPERIENCES
  - Discriminating stigmata
  - Marginalized populations
  - Advocacy
  - PRIDE
  - +/- overlapping identities

HB2 March 24, 2016

Washington (CNN) North Carolina’s governor on Wednesday signed a controversial bill blocking cities from allowing transgender individuals to use public bathrooms for the sex they identify as – as well as restricting cities from passing nondiscrimination laws more broadly.

House Bill 2, the Public Facilities Privacy & Security Act, puts in place a statewide policy that bans individuals from using public bathrooms that do not correspond to their biological sex. The bill also reserves the right to pass nondiscrimination legislation to the state government, saying state laws preempt any local ordinances.
What perpetuates Society's Perception of Gender?

Toys and Clothing Over Time

1880-1890's

1918: Pink for boys, blue for girls

1920's

1940's
What is Different about Today?
What contributed to this phenomenon?

1980’s

How has this come to be the norm?

We must Prepare!
Europe is ahead of the game

There is a whole community out there of parents and kids who are struggling with "My son really doesn’t want to wear boy clothes, but prefers to wear girl clothes.”

The fashion world may have divided children into pink and blue, but in the world of real individuals, not all is black and white.

Jo B. Paoletti

A U.K. Store Will Stop Labeling Its Kids Clothes as “Boys” and “Girls.” But It’s Not About the Kids.

Gender War, Aisle 3: Unisex Kids’ Clothes Stir British Backlash
A review of basic human needs experienced by the gender diverse population

Maslow's Hierarchy of Needs

- Physiological needs: food, water, warmth, sex
- Safety needs: security, safety
- Belongingness and love needs: close relationships, friends
- Esteem needs: prestige and feeling of accomplishment
- Self-actualization: self-fulfillment, including creative activities
- Self-actualization: self-actualization

Published February 2017
ustranssurvey.org
Basics: Shelter

- 7% general population is homeless
- 40% LGBTQ
- Runaway or forced out of home due to sexual orientation or gender identity
- 30% live below poverty line

Basics: Safety

Safety from Violence
2-3 x more likely to experience harassment
- Verbal, Physical, Emotional
- Assault
- Suicide 40%
- Decreased access to health care

63.9% of transgender youth report having ever been verbally attacked
80% of transgender youth reported feeling unsafe at school because of their gender expression

LOVE & Belonging

- Ostracized from Family
- Unable to express romantic feelings openly
- Trauma history can impair intimacy
Psychological: Education / Esteem

1/3 of trans kids drop out of school at some point due to bullying, bathroom issues, unacceptance
Increased overall Stress
½ unable to update drivers license
2-3x unemployment rate

Self Actualization

HOW?

Self-actualization: achieving one’s full potential, including creative activities
Esteem needs: prestige and feeling of accomplishment
Belongingness and love needs: intimate relationships, friends
Safety needs: security, safety
Physiological needs: food, water, warmth, rest

LGBTQ Youth Report

Published 5/2018
77% of LGBTQ youth surveyed report that on average they had felt down or depressed in the past week.

Only 41% had received psychological or emotional counseling to address these issues in the past 12 months.

LGBTQ youth of color face even greater challenges in accessing counseling services, with large disparities and an average of 33% of respondents having received psychological or emotional counseling in the past 12 months.

Importantly, youth who had received counseling reported better mental health outcomes.
Any MH Disorder

Depression

Suicidal Ideation

Suicide Attempt

T Clinic Experience
Active Patients
N=250

% RCH T-Clinic
% Gen Pop

% RCH T-Clinic
% Gen Pop

% RCH T-Clinic
% Gen Pop

% RCH T-Clinic
% Gen Pop

Any MH Disorder

↑3X

Depression

↑3X

Suicidal Ideation

↑1.6X

Suicide Attempt

↑4.8X

Remember your lens

- Your gender identity
- Your race
- Your assigned sex at birth
- Your socio-economic level
- Your sexual orientation

- Have you ever
  - Needed to explain your bathroom choice?
  - Corrected someone on your pronouns?
  - Been denied a job, or housing based on any of the above?
  - Felt unsafe in school, on campus, walking downtown?

A changing scene in Peds Endo

- After the 1960s gender reassignment surgery of children with “ambiguous genitalia” followed the view of scientists such as the Johns Hopkins psychologist John Money who argued that it was culture not nature that defined gender.

- In 1999, CAH adults came to speak to the Pediatric Endocrine Society to sway doctors to wait for surgery unless it medically necessary
  - Initial recognition of increased incidence of lesbianism in this population, more tomboys, and higher percentage of transgender identification than in other populations
  - First time physicians started to think in a more flexible way about gender and presentation of assigned sex
    - Some obstacles, of course
- Regarding transgender youth, nothing was publicly recommended to do until the individual was 18 yrs old.
Transgender Medicine in Youth is Quite New!

Up to 1990’s: Wait until 18 yrs of age

- 1990’s: Early treatment of trans youth in Netherlands
  - 16-18 yrs
- 2000: Netherlands practicing pubertal suppression
  - 12-18 yrs
- 2003: I graduated Fellowship
- 2006: Netherlands Protocol Published
- 2007: GeMs Clinic Boston : Dr Norman Spack
  - 1st Gender Center in US to treat Youth
- 2009: 1st publication of Endocrine Guidelines
- 2010: My first patient
- 2011: Grand Rounds
- 2013: Dr. Spack’s Ted talk
- 2014: Opening of T clinic

Since 2000: 12 - 16 years
‘Puberty Blockers’

Fully Reversible
Not gender reassignment but; extended diagnostic phase:
Creating time for a balanced decision regarding GR
Optimizing psychological health and well being
Passing successfully in the identified gender after GR

The Feasibility of Endocrine Interventions in Juvenile Transsexuals

Clinical management of gender identity disorder in adolescents:
a protocol on psychological and pediatric endocrinology aspects
Comparison of 2009 and 2017 Guidelines

2009
ALLOWED US TO TREAT
- Based on Dutch protocol
- Used Trans Sexual, GID
- Dx made by MHP who provides letter
- Suppression at Tanner 2
- Cross Hormones at 16 yr
- Only one strategy for HRT
- IM dosing of Testosterone
- Labs every 3 months
- Surgery after 18 yr

2017: Noticed differences in Populations
- Acknowledge the benefits of early social transition
  > Suggest with the help of a MHP
- Diagnosis by MHP
- Suppression in Adolescents at Tanner 2
- Cross hormones at 16 with understanding that 13-14 is acceptable
  > Different protocol for naive and pubertal kids
- Sub Q or IM dosing of testosterone
- Labs less frequently
- Acknowledge 16 yr for top surgery
- 18 yrs suggested for GU surgery
Today

- November 2017 Revised Guidelines published
- Over 60 programs treating gender diverse youth across the country
- Many institutions have Comprehensive TransGender Services
- Media and Visibility has increased tremendously
- President Obama was helpful
- RCH has contacted over 290 patients and families, have over 200 established patients.
  > 2017: 106 new referrals
  > Goes up exponentially every year

275 New Patients Since 2010

![Graph showing RCH T Clinic New Patient Referrals]

New Referrals 2018 / 2017

![Bar chart comparing new referrals between 2016 and 2017]

Totals So Far: 2018: 72  2017: 68
The Young Ones

Gender Reveal Parties

- "Although sex of rearing (assigned sex) can be assigned at birth, gender identity can only be assumed, and not, in fact, known until an individual achieves a particular level of psychological development and self-awareness."
  - Dr. Rosenthal, UCSF
- "He is male, until he tells us otherwise."
  - Lisa Goren, regarding her 6 month-old son

Cathy Thorne © www.everydaypeoplecartoons.com

DO YOU KNOW WHAT YOU'RE HAVING? A HUMAN BEING.
Development

- **By age 3**: interest in or preference toward non-stereotypically gendered activities and behaviors are NON–INTENDED
  - “Little kids do not ‘Come Out’”

- **By age 3-5**: Children are
  - Consistent
  - Persistent and
  - Insistent
  About their Gender Identity

- **By age 5-6**: social pressure is understood and kids understand pressure to conform.

What does it mean to be Transgender?

- Gender Dysphoria is the Psychological Term
  > DSM-V

- **Distress** caused by the incongruence between one’s expressed or experienced (affirmed gender) and the gender assigned at birth

- Often apparent as early as at age 2

Transgender in the young

<table>
<thead>
<tr>
<th>Consistent</th>
<th>Insistent</th>
<th>Persistent</th>
</tr>
</thead>
</table>

Jo Olson, LA Children's
Atypical Gender Interests

- Parental Suppression of Autonomy
- Parental Exploration of Gender
- Repression: Anxious, Angry Child
- Fearful Parent, Happy Kid
- At Risk for Serious Negative Health Outcomes
- Well Adjusted Kid

Mental Health of Transgender Children Who Are Supported in Their Identities

Stage 1: Social Transitioning

- Outward expression of internal gender
- Clothes, hairstyles, names, pronouns
- Kids typically function better during this time
- Prior to puberty, it is pretty easy to transition into the opposite gender role physically
- LIVE in affirmed gender
- REVERSIBLE
If you see someone who needs help:
Call Us!

- Nurses can connect with families
- Will have social worker soon to help coordinate care
- We have a list of people who have an interest and are experienced in TransGender Care and Gender Dysphoria Diagnosis in the Portland Area

Medical Intervention Part 1: Pubertal Suppression

Changes of Puberty

50 males avg 11 yrs Testicular enlargement
50 females avg 10 yrs Breast development
Concept of Puberty Blockers Suppression

GnRh Agonists

Identical twins: a natural control
A word about the “Blockers”

- Originally marketed to “buy time”
- Very expensive
- By suppressing endogenous production of hormones, in theory you can have less competition for effects of cross hormones
- Not the best choice for everybody, and I by no means put all adolescents on suppressors
  - Especially if already further into puberty
  - Designated Females
    - Menstruating: can cease periods, but cause menopausal feelings
    - Bone health is an issue
  - Designated Males

Pubertal Suppression: Ideal for early puberty

Medical Intervention Part 2: Cross Hormones
Starting Hormones

- Every kid wants them started yesterday
- I will start having the conversation around 13 years of age, for preparation by 14 yrs
  > Individual path
  > Ideally have parents on board

- Need to see a mental health provider to determine “readiness”
  > Looks different depending on provider approach
  > I do informed consent
  > Offer to see fertility specialist

Cross Hormones: Start talking at 13 yrs
Female Affirmed on GnRh Agonist (Naïve)

Randall Children’s Estrogen Protocol

**RCH Pubertal Affirmed Female Dosing Protocol**

**Table 1:**

<table>
<thead>
<tr>
<th>Hormone</th>
<th>Initial Dose</th>
<th>Maximum Total</th>
<th>Initial Increment</th>
<th>Maximum Increment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estradiol</td>
<td>5.0 mg 3x/week</td>
<td>20.0 mg 3x/week</td>
<td>1.5 mg/week</td>
<td>6.0 mg/week</td>
</tr>
</tbody>
</table>

**Table 2:**

<table>
<thead>
<tr>
<th>Hormone</th>
<th>Initial Dose</th>
<th>Maximum Total</th>
<th>Initial Increment</th>
<th>Maximum Increment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testosterone</td>
<td>0.1 mg 3x/week</td>
<td>0.5 mg 3x/week</td>
<td>0.05 mg/week</td>
<td>0.2 mg/week</td>
</tr>
</tbody>
</table>

**Table 3:**

<table>
<thead>
<tr>
<th>Hormone</th>
<th>Initial Dose</th>
<th>Maximum Total</th>
<th>Initial Increment</th>
<th>Maximum Increment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progesterone</td>
<td>3.0 mg 3x/week</td>
<td>12.0 mg 3x/week</td>
<td>1.0 mg/week</td>
<td>4.0 mg/week</td>
</tr>
</tbody>
</table>

**Table 4:**

<table>
<thead>
<tr>
<th>Hormone</th>
<th>Initial Dose</th>
<th>Maximum Total</th>
<th>Initial Increment</th>
<th>Maximum Increment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cortisol</td>
<td>1.0 mg 3x/week</td>
<td>4.0 mg 3x/week</td>
<td>0.5 mg/week</td>
<td>2.0 mg/week</td>
</tr>
</tbody>
</table>

**Table 5:**

<table>
<thead>
<tr>
<th>Hormone</th>
<th>Initial Dose</th>
<th>Maximum Total</th>
<th>Initial Increment</th>
<th>Maximum Increment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Melatonin</td>
<td>0.5 mg 3x/week</td>
<td>2.0 mg 3x/week</td>
<td>0.25 mg/week</td>
<td>1.0 mg/week</td>
</tr>
</tbody>
</table>

**Table 6:**

<table>
<thead>
<tr>
<th>Hormone</th>
<th>Initial Dose</th>
<th>Maximum Total</th>
<th>Initial Increment</th>
<th>Maximum Increment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adrenaline</td>
<td>0.1 mg 3x/week</td>
<td>0.5 mg 3x/week</td>
<td>0.05 mg/week</td>
<td>0.2 mg/week</td>
</tr>
</tbody>
</table>

**Table 7:**

<table>
<thead>
<tr>
<th>Hormone</th>
<th>Initial Dose</th>
<th>Maximum Total</th>
<th>Initial Increment</th>
<th>Maximum Increment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renin</td>
<td>0.1 mg 3x/week</td>
<td>0.5 mg 3x/week</td>
<td>0.05 mg/week</td>
<td>0.2 mg/week</td>
</tr>
</tbody>
</table>

**Table 8:**

<table>
<thead>
<tr>
<th>Hormone</th>
<th>Initial Dose</th>
<th>Maximum Total</th>
<th>Initial Increment</th>
<th>Maximum Increment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin</td>
<td>0.1 mg 3x/week</td>
<td>0.5 mg 3x/week</td>
<td>0.05 mg/week</td>
<td>0.2 mg/week</td>
</tr>
</tbody>
</table>

**Table 9:**

<table>
<thead>
<tr>
<th>Hormone</th>
<th>Initial Dose</th>
<th>Maximum Total</th>
<th>Initial Increment</th>
<th>Maximum Increment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucose</td>
<td>0.1 mg 3x/week</td>
<td>0.5 mg 3x/week</td>
<td>0.05 mg/week</td>
<td>0.2 mg/week</td>
</tr>
</tbody>
</table>

**Table 10:**

<table>
<thead>
<tr>
<th>Hormone</th>
<th>Initial Dose</th>
<th>Maximum Total</th>
<th>Initial Increment</th>
<th>Maximum Increment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatty Acid</td>
<td>0.1 mg 3x/week</td>
<td>0.5 mg 3x/week</td>
<td>0.05 mg/week</td>
<td>0.2 mg/week</td>
</tr>
</tbody>
</table>
RCH Testosterone Induction Protocol (Naïve)

- Dosing:
  - 45 mg (0.25 mg/kg) weekly for 4 months
  - 60 mg (0.3 mg/kg) weekly for 4 months
  - 90 mg (0.5 mg/kg) weekly after 6 months of 45 mg 3 times weekly

- Initial Data:
  - Mean: 10.6 ng/mL
  - Median: 7.0 ng/mL

- Adult Data:
  - Mean: 450 ng/mL
  - Median: 400 ng/mL

RCH Pubertal Testosterone Protocol

- Dosing:
  - 45 mg (0.25 mg/kg) weekly for 4 months
  - 60 mg (0.3 mg/kg) weekly for 4 months
  - 90 mg (0.5 mg/kg) weekly after 6 months of 45 mg 3 times weekly

- Initial Data:
  - Mean: 10.6 ng/mL
  - Median: 7.0 ng/mL

- Adult Data:
  - Mean: 450 ng/mL
  - Median: 400 ng/mL

OHSU/ RCH Testosterone Dosing Study

- Medication:
  - Testosterone (T)
  - Androgen (A)

- Dosing:
  - T: 5 mg/2 cm
  - A: 3 mg/kg

- Initial Dosing:
  - T: 5 mg/2 cm
  - A: 3 mg/kg
Surgery

Surgical Options for FTM
- Breast reconstruction
- Neoscytum with testes prostheses
- +/- metoidioplasty
  - Separates the enlarged clitoris from the labia minora
  - Severs the suspensory ligament to approximate the location of a penis
  - May extend the urethra to allow to urinate while standing
  - Still have chordee organ
- Creation of microphallus from hypertrophic clitoris
- Phalloplasty
- Hysterectomy + oophorectomy

Surgical Options MTF
- Vaginoplasty
  - Orchidectomy
  - Perinectomy
  - Penile inversion
  - Cistoplasty
  - Creation of labia from scrotal skin
  - Nerve sparing
- Breast augmentation
- Facial feminizing surgery
- Fat transplants
Nuances of Peds

- Early vs. Late Presentation
- Role of Mental Health in Youth
- Clinical
  - Height Curve
  - Bone Age Standards
  - Lab Normal Values
- Non-Binary Considerations
What about kids who come out at an older age?

- Late Onset Gender Dysphoria
  - After puberty has initiated, and often after it has completed or as an adult
  - Lots of different ways these kids present
    - I always knew I was different
    - I thought I was gay, Parent thought they had a gay kid
    - She was always a tomboy
    - Realized something was wrong when puberty hit
    - Periods are AWFUL
    - Read about TRANSGENDER on Tumblr and realized they were talking about me
    - One of my friends……

Early Vs Late Onset Gender Dysphoria

- Early Onset
  - Do not see themselves as different
  - Always was a [ ]
  - No block against gender change, they always saw themselves as the other gender

- Late Onset (one theory anyway)
  - Realize later, due to a block against gender change
    - Could be inherent, could be societal (are socialized into accepting their cis gender role)
    - Some feel that the block is not solid, and has the potential to be weakened or removed at some point
Late Onset Gender Dysphoria

- Medical History
  - Hormone exposure
    - CAH experience, PCOS
    - Testosterone levels

- Importance of Mental Health Involvement
  - Trauma: something happens to them as their DSAB which repels them from wanting to be the corresponding gender.
  - Failure or deep personal crisis: the belief that the person they are has in some way completely failed...therefore creating fertile ground for the creation of a new persona.
  - Stagnation: a person believes their life is utterly devoid of interest and excitement and being reborn with a new identity becomes the desired solution.
  - Change in role: divorced, single, some kind of change which means they no longer have to play the DSAB role.
  - Increasing independence from social conditioning: as an individual gets older they often become more independent and begin to shape their own view rather than that shaped by parents and peers and prevailing ideas. The individual can think objectively and start to question their identity, sexuality and how they view the world. In this new world view there may be a release of repressions.

Complicated Kids....

Suicide

- 25/118 (21.2%) Admitted to or had documentation of Psychiatric Hospitalization
- 29/118 (24.6%) were either not attending school or were on an online program
- Suicidal ideation / attempt / hospitalization

![Graph showing suicide rates from 2010-2016](image)
Data from 2017: 118 patients seen in T clinic

Ages of Patients Seen in 2017

ED Visit in Past 90 Days: in 12/2017
1 Sexual Abuse
4 Suicidal Ideation/Attempt
Annualized 17%

Importance of Mental Health in Youth with Gender Dysphoria

- Adolescence is a very important developmental stage
- Must take into account understanding of consequences of actions of hormones
- Ideally would like to have parents supportive
- Much different than with Adult with Gender Dysphoria
  > Informed Consent Model
- Age of Majority
- History of Trauma

Nuances in Pediatrics
The Art vs. the Science of Medicine
Which Standards to Use? Growth Charts

- Patient is DFAB; identifies male; 11.5 yrs of age, height 56"
- Mother is 5'2" and Father is 5'10"

Bone Age

- 12 yr female Bone Age
- 14 yr male Bone Age

Overcoming Barriers to Care: Organizational Strategies

- Display posters or flyers that include LGBTQ youth, same-sex couples, and symbols
- Train all staff on LGBT health and competencies
- Offer single stall, gender-neutral bathrooms
- Include gender identity and sexual orientation in non-discrimination policies
- Allow patients to identify their sexual orientation and gender identity, as well as preferred name and pronouns on appropriate forms
- Develop office policy in compliance with local laws regarding confidentiality for unemancipated minors
Gender Identity Questions for Registration (Example)

• What is your current gender identity? (check ALL that apply)
  □ Male
  □ Female
  □ Transgender Male/Trans Man/FTM
  □ Transgender Female/Trans Woman/MTF
  □ Genderqueer
  □ Additional Category (please specify) _________

• What sex were you assigned at birth? (Check one)
  □ Male
  □ Female
  □ Decline to Answer

- What is your preferred name and what pronouns do you prefer (e.g. he/him, she/her, ze, they)?

Communication Tips

• Politely ask if you are unsure about a patient’s preferred name.
  - What name would you like us to use today?
  - I would like to be respectful, how would you like to be addressed?

• Ask respectfully about names if they do not match your records.
  - “Could your chart be under another name?”

• Did you make a mistake? Apologize.
  - “I am sorry for using the wrong pronoun. I did not mean any disrespect.”

• Only ask for information that is required.
  - Ask yourself: What do I know? What do I need to know? How can I ask in a sensitive way?
What if I am unsure?

...the patient looks different than what is stated in the medical record (front desk; MA, lab etc)

- **DO:** ASK!
  - state last name, confirm DOB, then ask preferred name
  - “What name do you preferred to be called?”
  - “What pronouns would you like me to use in addressing you?”
- Can search by BOTH MR name and preferred name
- **DON’T:** assume anything
- **DON’T:** use MR first name if you are unsure.
  - You can
    - Ask the parent.
    - Go by last name, and then ask
  - Have had patients be quite upset at being called the name in the MR in a public venue (lab)

EMR Does Not Make Things Easy

- Given (Dead) Name is in EMR unless it is changed on insurance card
  - Have to legally change name, this is a process
  - If name does not match insurance card, insurance will not pay
- Legally changing name does not change sex assigned at birth (in the EMR)
- Only have spots for sex (M/F) and not identified gender
- If sex is changed in EMR, then normals for lab and radiological values differ and are often inaccurate (esp in ped)

Well, why is it discrepant?

- Name on insurance card must match that on the medical chart in order to be covered
- A formal name change is a process, sometimes involves going to court
- Even if name changed, assigned sex stays same, and pt is FYI transgender
  - Remember sex and gender are 2 different things!
- Labs for assigned sex need to match normals for assigned sex (for interpretation) in children
- Growing children are plotted on assigned sex growth curves.
EMR: EPIC Banner

- FYI in RED
- Has:
  > Preferred Name
  > Preferred Pronouns
  > Affirmed Gender
- AND Any one can enter it!

T-Clinic Patient Age Distribution

Avg: 15 yrs
Med: 16 yrs
"68.5% with chart FYI"
Epic : Charting

- Difficult
- When using templates, data is auto populated with what is in EMR
  - if in EMR as male, will auto populate with he and given male name
- Can use disclaimer at beginning of the note
- Can have your templates say “the patient” instead of he/she, or have *** for you to fill in preferred name, can have preferred name populate it.
- Generate templates for gender diverse kids. (A lot of work)

Do Not

- Make remarks that you think they can not hear, they can
- Ask questions about what is in their pants if they are in for something unrelated
- Disregard their transition and identity in your notes and interactions

Lastly...

- And if you mess up, and make a mistake
  > It happens! Especially if you know them pre-transition!!!!
- Acknowledge it, apologize and move on.
Please Remember

- These kids are extremely vulnerable, and already are suffering mental issues.
- To be addressed in their assigned sex gender role can be very upsetting when they have made such gains in social transitioning and getting to medical care.
- We are a special population that actually needs to know that they are transgender. In most other realms of life and society, NO ONE NEEDS TO KNOW.
- Thus, honor our privilege to serve them and call them by their affirmed name and pronoun.
Thank you!