



QUESTIONNAIRE FOR PROVIDERS FOR TRANSGENDER MEMBERS

IEHP is interested in identifying Providers who have experience and interest in providing high quality care to Transgender Members. Please complete the following survey if you would like to be listed in our Provider Directory, as a Provider available to our Transgender Members.

LAST NAME: _____ **FIRST NAME:** _____
SPECIALTY: _____ **EMAIL:** _____
PHONE: _____ **FAX:** _____

1. Please assess your ability in providing high quality care to Transgender Members:

- Advanced Moderate Minimal No experience
 (Move to Question 6)

2. Approximately how many Transgender patients have you cared for in the past twelve (12) months?

- None 1 – 2 3 – 9 10 – 25 Over 25

3. How long have you been providing care to Transgender patients?

- Under 1 year 1 – 5 years 5 – 9 years Over 10 years

4. What training, if any, have you received to treat Transgender patients? (Please provide documentation for all that apply)

- CME events. Please list organization that provided CME: _____

- Are you a Member of World Professional Association for Transgender Health (WPATH)?

- Transgender certifications through WPATH, date: _____

- None Other: _____

5. What clinical practices guidelines/resources do you use in providing transgender care? (Select all that apply)

- WPATH Standards of Care
 UCSF Center of Excellence for Transgender Health – Guidelines for the Primary and Gender – Affirming Care of Transgender and Non-Binary People
 Endocrine Society Clinical Practice Guidelines None
 Other, please list: _____

6. What steps have you taken to make your practice trans-friendly? (Select all that apply)

- Date of most Recent Staff training for transgender care: _____
 Submitted copy of Office policies/procedures Bathroom policies
 Unique gender identification/name/pronoun capture in EMR? None



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7. **Have you ever written a letter to support the acquisition of gender affirming surgery?**
- Yes No
8. **Are you willing to write letters to support the acquisition of gender affirming surgery?**
- Yes No
9. **How many of these letters have you written in the past twelve (12) months?**
- None 1 – 3 3 – 10 Over 10
10. **What resources would you recommend IEHP offer to support you in your efforts at providing high quality transgender care? Any other comments:**

TRANSGENDER SERVICES AND SKILL LEVEL

Listed below are services for Transgender members. Please identify your ability or skill level for each service.

ABILITY/ SKILL LEVEL				SERVICE	
No Experienc	Minimal	Moderate	Advanced		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast Augmentation	Feminizing Procedure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Facial/Body Hair Removal	Feminizing Procedure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Facial Feminization	Feminizing Procedure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital Laser/Electrolysis	Feminizing Procedure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hormone Treatment	General
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hysterectomy with or without Oophorectomy	Masculinizing Procedures
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Integrated Mental and Physical Health Service Model	General
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mastectomy with male chest reconstruction	Masculinizing Procedures
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Services	General
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metoidioplasty	Masculinizing Procedures
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Orchiectomy	Feminizing Procedure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phalloplasty	Masculinizing Procedures
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Procedures (Office Based, please describe: _____	General
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Voice Therapy	General