



## Consent Form for Progestin Therapy

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Manitoba Health PHIN #: \_\_\_\_\_

Evidence suggests that the addition of progestin to my hormone regimen adds significant risk to my treatment over and above the risks of estrogen.

Sherbourne Health Center's "Guidelines and Protocols for Hormone Therapy and Ongoing Primary Care for Trans Clients" does not suggest the use of progestins.

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

- Coronary heart disease
- Stroke
- Deep vein thrombosis
- Pulmonary embolism
- Invasive breast cancers
- Psychiatric symptoms (depression and suicidal feelings)

Other potential adverse side effects of progestins may also include, but are not limited to, the following:

- High blood pressure
- Liver inflammation
- Breast tenderness
- Migraines or other headaches
- Increased cholesterol
- Diabetes
- Acne
- Body hair growth
- Weight gain / bloating and fluid retention
- Worsening of asthma
- Worsening of seizures

Some side effects of progestins 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

I understand that progestin should not be taken by people who have, or have had, any of the following:

- Active liver dysfunction
- Allergy to progestins, soy, peanuts
- Estrogen or progestin-dependent breast cancer
- Coronary artery disease
- Myocardial infarction
- Stroke
- Blood clots
- Migraine with aura

My signature below constitutes my acknowledgement of the following:

\_\_\_\_\_  
(Name of care provider)

has discussed with me the benefits and risks of progestins, including the risk that hormone therapy may not accomplish the desired objective; the possible or likely consequences of progestin; and all feasible alternative diagnostic or treatment options.

- ☐ I have read and understand the above information regarding the hormone therapy, and accept the risks involved.
- ☐ I have had sufficient opportunity to discuss my condition and treatment with my medical provider 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.
- ☐ I authorize and give my informed consent to the provision of hormone therapy.

***Whatever your current decision is, please talk with your doctor any time you have questions, concerns, or want to re-evaluate your options.***

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Based on Sherbourne Health guidelines:

<https://www.rainbowhealthontario.ca/wp-content/uploads/2021/06/Guidelines-FINAL-4TH-EDITION-c.pdf>