OKLAHOMA DEPARTMENT OF CORRECTIONS

Female to Male
Hormonal Therapy Risk and Information Form

Hormone therapy may be all the treatment you need for your gender dysphoria. While you are being treated with hormones, you will be monitored to determine if the hormone treatment is benefiting you. Before starting hormone treatment you are encouraged to exercise regularly and stop smoking. Exercise improves the benefits of hormone treatment, while smoking causes increased risks associated with hormone treatment.

Blood tests will be taken to determine your health and suitability to begin hormone therapy. Some people may be unable to take hormones due to other health conditions.

You may be frustrated with how long hormone therapy takes to produce results, and you will need to be realistic about the extent of changes you can expect. For example, hormones cannot change the shape or height of your skeleton.

Testosterone can be prescribed for transsexual men with gender dysphoria and is often helpful in making their appearance more masculine. Noticeable changes may include:

- your voice may get deeper
- your body may redistribute body fat into a more male shape
- you may have more muscle tone
- you may develop male pattern body and facial hair growth
- you may have an increased sex drive
- your clitoris (a small, sensitive part of the female genitals) may get bigger
- your periods may stop

Testosterone side effects may also include:

- liver complications
- acne
- male pattern baldness
- allergic reaction
- chest pain
- heart attack
- hearing loss
- ringing in the ears
- diarrhea
- abdominal pain
- nausea
- swelling
- blood glucose level changes
- elevation of blood pressure
- elevation of cholesterol and/or triglycerides
- musculoskeletal pain

These potential effects and side effects make it important to have regular medical check-ups.

I have read the effects and side effects of the medication(s) which are being prescribed to me for gender dysphoria. I accept the potential risks inherent in this treatment. I have been given the opportunity to ask questions and discuss my treatment with my health care provider. By signing below, I acknowledge the risks, verify my understanding of the information provided, and consent to treatment with the medication(s) prescribed to me for gender dysphoria.

Signature: _____ Date: _____

Printed Name: _____ DOC#: _____

Witness: _____ Title: _____ Date: _____

Witness: _____ Title: _____ Date: _____

Inmate Name (Last, First) DOC #