Before considering to give treatment to your child to suppress puberty (put puberty "on hold" with "puberty blockers"), you need to be aware of the possible benefits and risks.

After your questions or concerns are addressed and you have decided to proceed with puberty suppression for your child, you will need to initial the statements of this form as well as sign the consent form. If there is more than one parent/legal guardian, both will have to sign. Your child will also need to assent this form.

What are the benefits of suppressing puberty in adolescents with gender dysphoria?

The Endocrine Society recommends suppression of puberty (put puberty "on hold" with "puberty blockers"), for children that have the diagnosis of gender dysphoria as well as other specific criteria listed in the section below. This recommendation was done by experts in treating youth with gender dysphoria, based on the premise that this may: allow for a smooth social transition to the gender role that is congruent with their gender identity; test persistence of the affirmed gender after living a “real-life experience” and before receiving irreversible hormonal or surgical treatment; and diminish the psychological trauma and risk of suicide induced by the physical changes of puberty.

This may also avoid the need for surgery and other expensive treatments that are required to reverse the physical effects of puberty (i.e. mastectomies, tracheal and facial shaving, and electrolysis).

What are my other options if I do not wish to have my child undergo treatment for suppression of puberty?

The only other option available is psychological therapy with a mental health provider that has experience in treating youth with gender dysphoria. We recommend this regardless of whether your child undergoes suppression of puberty or not, due to the high risk of anxiety, depression, self-harm and even suicide. No studies have been done comparing psychological therapy only versus suppression of therapy.
What are the different medications that are used to suppress puberty?

The main mechanism by which physical changes of puberty can be put on hold is by blocking the signal from the brain to the organs that make the hormones of puberty. These hormones are estrogen and testosterone. Estrogen is made by the ovaries. Testosterone is made by the testicles.

The medications are also called “pubertal blockers” and are effective for both males and females. They can be started just after the early physical changes of puberty. None of them have been approved by the Food and Drug Administration (FDA) to be used in adolescents with gender dysphoria, in other words, this is an “off label” use. However, pediatric endocrinologists (children’s doctors who specialize in hormones and puberty), use these medications frequently to suppress puberty in children with precocious (early) puberty.

Lupron and Histrelin are called GnRH analogs and are the most effective forms of treatment. Lupron is given as a monthly or every 3 month intramuscular injection and is approved for children with precocious (early) puberty. Histrelin is an implant that is placed under the skin surgically, and needs to be replaced yearly to every 2 years. Histrelin is approved for children with precocious puberty with the brand name of Supprelin, and on a slightly smaller dose, it is approved in adults with prostate cancer under the name of Vantas. Provera is a pill that needs to be taken twice a day and is approved to be used in female adolescents with abnormal uterine bleeding. Provera was used for early puberty before Lupron and Histrelin were available, and is less effective in suppressing puberty.

What are the requirements to receive suppression of puberty for gender dysphoria in our program?

In order to receive therapy to put puberty on “hold” at our center, there are specific requirements that need to be met before and during the treatment. Although this therapy is considered standard of care, this is a new area of medicine and we want to provide the safest treatment. These requirements will allow us to monitor your child’s medical as well as mental health wellbeing during hormone therapy. If these requirements are not met, treatment with puberty blockers may be discontinued in the best interest and safety of your child.

Before beginning treatment with a “puberty blocker” your child needs to undergo a thorough psychological and social evaluation performed by our GENECIS team. We also require your child has participated in at least 6 months of psychological therapy. We will need a letter from your child’s therapist confirming this. Your child will need to have started puberty, which varies from person to person but usually occurs after age 8.
After all this has taken place, treatment to suppress puberty can be initiated if your child meets specific criteria established by the Endocrine Society, which includes ALL of the following:

1. Fulfill the current DSM or ICD criteria for gender dysphoria or transsexualism.
2. Have (early) pubertal changes that have resulted in an increase in gender dysphoria.
3. Do not suffer from psychiatric comorbidity that interferes with the diagnostic work-up or treatment.
5. Have experienced puberty to at least Tanner stage 2: this is the first stage of puberty and refers to breast or testicle growth; has to be confirmed by a physician.
6. Demonstrate knowledge and understanding of the expected outcomes of suppression of puberty, future cross-sex hormone treatment, and sex reassignment surgery, as well as the medical and social risks and benefits of sex reassignment.

After treatment for suppression of puberty has been initiated, the following will be required:

1. Visits with the endocrinologist or adolescent medicine physician in our program every 3 months.
2. Suicide risk assessment performed by our social worker during each clinic visit every 3 months.
3. Laboratory testing every 3-4 months.
4. X-ray of the hand (bone age) once a year.
5. Bone (dexa) scan: this will allow us to monitor your child’s bone density (bone strength) during treatment, since puberty blockers may decrease bone density if given for long periods of time.
6. Yearly mental health assessment and completion of questionnaires with a member of our mental health care team. This will allow us to monitor your child’s psychological wellbeing and adjustment while on puberty blockers.
7. Continued counseling with a therapist during the treatment period, with the frequency recommended by the therapist.

Please initial each statement on this form to show that you understand the benefits, risks, and changes that may occur from giving treatment for suppression of puberty to your child.

Effects of Treatment of Suppression of Puberty

_____ I know that puberty blockers are used to help temporarily suspend or block the physical changes of puberty for my child.
I know that the effect of this medication is not permanent. If my child stops treatment, in a few months my child’s body will restart the changes of puberty at the developmental stage they were at when they started the treatment.

I know that it can take several months for the medication to be effective. I know that no one can predict how quickly or slowly my child’s body will respond.

I know that by taking these medications, my child’s body will not be making the hormones of puberty, testosterone or estrogen. At this time, I support my child in “putting on hold” the hormones and the changes induced by puberty.

I know that the use of these medications in adolescents with gender dysphoria are off-label use. I know this means it they are not approved by the FDA for this specific diagnosis.

**Risks of Treatment of Suppression of Puberty**

I know that information on adverse effects and safety of these medications used in transgender youth is not well known.

I realize that this treatment may not be able to completely prevent serious psychiatric events such as a suicidal attempt.

I know that the treatments to suppress puberty may induce weight gain.

I know that the treatments to suppress puberty may decrease bone density.

I know that my child may grow less than his/her peers while on these medications.

I realize there may be a stalling of typical adolescent cognitive or brain development while on these medications.

I know that stopping the development of puberty for my child may have social consequences.

**Requirements of Treatment of Suppression of Puberty**

I understand and agree with all the requirements explained above, in order to receive suppression of puberty therapy in our program.
I know that the mental health team and/or treating physician may recommend to stop treatment because it no longer outweighs the risks, there is insufficient social or psychological support, or our program requirements to treat are not met. In this case, we will not continue to prescribe drug therapy.

I know that I am responsible for the cost of the medical management, including medical appointments, psychological evaluations, laboratory and imaging tests, as well as drug therapy.

I know that I can change my mind and decide to stop treatment at any time.

I agree to tell a member of our GENECIS team if you think your adolescent has any problems or is unhappy with the treatment.

I know that after my child turns 21, medical care will have to be transitioned to an adult endocrinologist.

Prevention of Complications while under Treatment of Suppression of Puberty

I agree to tell my health care provider if my child has any problems or side effects or is unhappy with the medication, and in particular, if you have concerns that your child has worsening signs of depression or anxiety, or wants to harm him/herself or attempt suicide.

I know my child needs periodic medical evaluations clinic to make sure that my child is responding appropriately. This includes clinic visits with the pediatric endocrinologist or adolescent medicine every 3 months, laboratory and imaging tests.

I agree to have my child on continued psychological therapy or counseling with the frequency recommended by his therapist.

PARENTAL CONSENT:

Our signatures below confirm that:

- My child’s health care provider has talked with me about:
  a) the benefits and risks of puberty blockers for my child.
  b) the possible or likely consequences of using puberty blockers.
  c) potential alternative treatments.
- I understand the risks that may be involved.
I know that the information in this form includes the known effects and risks. I also know that there may be unknown long-term effects or risks.

I agree with the requirements to receive puberty blockers in this program.

I have had enough opportunity to discuss treatment options with my child’s health care provider.

All of my questions have been answered to my satisfaction.

I believe I know enough to give informed consent for my child to take, refuse, or postpone using puberty blocking medications.

My child is in agreement with this treatment and the signature of my child on the assent form attests to this agreement.

My signature attests to my consent for my child to begin treatment for suppression of puberty.

Based on all this information:

_____ I want my child to receive puberty suppression treatment as prescribed.

_____ I do not wish my child to receive puberty suppression treatment at this time.

_________________________________________
Parent or legal guardian’s name

_________________________________________                     _________________________
Parent or legal guardian’s signature                     Date

_________________________________________
Parent or legal guardian’s name

_________________________________________                     _________________________
Parent or legal guardian’s signature                     Date

_________________________________________
Prescribing clinician’s name

_________________________________________                     _________________________
Prescribing clinician’s signature                     Date

ASSENT OF A MINOR:
I have discussed the benefits and risks of treatment to suppress puberty with my parent(s) or legal guardian(s), and I wish to receive it.

__________________________________________________
Minor’s Name (printed)

__________________________________________________
Minor’s Signature Date