



**GENDER AFFIRMING CARE MANAGEMENT PLAN - MASCULINISING
PREVENTATIVE HEALTH CARE PLAN
TEAM CARE ARRANGEMENT**

**Important Note:
Chronic Care Management Plans must be individualised for
each patient to ensure Medicare compliance.**

GP Management Plans (721): ____ / ____ / ____ (date of service)

Team Care Arrangements (723): ____ / ____ / ____ (date of service)

Reviews (732): ____ / ____ / ____ (date of service)

PATIENT DETAILS

ALLERGIES

No known allergies/adverse reactions.

GENDER DETAILS

GP

Gender identity: <insert gender>
Gender presumed at birth: F
Pronouns:

HISTORY LIST

Inactive:
Date Condition -- Comment

MEDICATIONS

GENDER AFFIRMING CARE MANAGEMENT PLAN TEMPLATE - REVIEW DUE:

Health Care Need/ Issue/ Condition	Management Goals	OTHER care providers Results/ appointments	ACTION ("TO DO") LIST:
<p>Gender incongruence - physical aspect (marked & persistent incongruence between experienced & assigned gender)</p> <p><i>Reference: ICD-11 (Version 04/2019)</i></p>	<p>Affirmation of experienced gender through medical &/or surgical treatment and supported social &/or legal gender affirmation as desired</p>	<p>Other health care providers:</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Regular review of goals for gender affirmation <input type="checkbox"/> Regular monitoring of treatment for efficacy, side effects & concerns <input type="checkbox"/> Healthy lifestyle measures to support physical & mental health & reduce risk of chronic disease
	<p>Gender affirming hormonal treatment - testosterone replacement</p> <p>Testosterone replacement for gender affirmation</p> <p><u><insert patient name></u> <u>goals:</u></p>	<p>Other health care providers:</p> <p>Results:</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Inform patient that no genital or chest exam is necessary in order to access hormonal affirmation <input type="checkbox"/> Education re expected physical & mental changes & limitations of therapy <input type="checkbox"/> Regular review with GP <input type="checkbox"/> Endocrine/ sexual health physician review, if appropriate <input type="checkbox"/> Testosterone replacement details: <ul style="list-style-type: none"> <input type="checkbox"/> Target testosterone: <ul style="list-style-type: none"> AusPATH target = 10-15nmol/L (trough) <INSERT NAME>'s target = (outline reasons if difference in targets) <input type="checkbox"/> Regular blood tests, initially 6-12 weekly, then as advised/ symptomatically <input type="checkbox"/> Discuss with Dr any treatment concerns
	<p>Gender affirming hormonal treatment - side effects</p> <p>Early identification & management of treatment side effects</p> <p><u><insert patient name></u> <u>goals:</u></p>	<p>Other health care providers:</p> <p>Results:</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Education re potential side effects of treatment <input type="checkbox"/> Targeted management of side effects as appropriate <input type="checkbox"/> Regular blood tests <input type="checkbox"/> Discuss with Dr any treatment concerns <input type="checkbox"/> Acne <ul style="list-style-type: none"> Topical treatment: Referral to dermatologist for isotretinoin <input type="checkbox"/> Persistent uterine bleeding <ul style="list-style-type: none"> Rule out pathological causes (CST, USS, STI testing as indicated) Consideration of hormonal IUD <input type="checkbox"/> Polycythemia <ul style="list-style-type: none"> Regular monitoring of red cell count/ oct Use of male normal values Smoking cessation Treatment modification/ haematology input as indicated <input type="checkbox"/> Vaginal dryness / atrophy <ul style="list-style-type: none"> Vaginal moisturisers, e.g. Replens/ Sylk Topical oestrogen Surgical management if appropriate

Health Care Need/ Issue/ Condition	Management Goals	OTHER care providers Results/ appointments	ACTION ("TO DO") LIST:
	<p><i>Gender affirming hormonal treatment - fertility affects</i></p> <p>Identification & appropriate management of fertility goals & use of appropriate contraception</p> <p><u><insert patient name></u> <u>goals:</u></p>	<p>Other health care providers:</p> <p>Results:</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Discussion of current & fertility concerns <input type="checkbox"/> Discuss with Dr any fertility concerns <input type="checkbox"/> Consider egg freezing if appropriate <input type="checkbox"/> Contraception as indicated (testosterone & amenorrhoea is not sufficient for contraception) including barrier methods, IUD & surgery
	<p><i>Other gender affirming treatment</i></p> <p>Identification of & facilitation of treatment for other goals of gender affirmation including surgery, vocal training, chest binding, etc. as appropriate</p> <p><u><insert patient name></u> <u>goals:</u></p>	<p>Other health care providers:</p> <p>Results:</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Surgical referral, if/ when appropriate <input type="checkbox"/> Speech therapy referral, if/when appropriate <input type="checkbox"/> Safe use of chest binding - use properly sized commercial binder, remove for sleeping, max. 8-12 hrs, Power's 4 finger check; review if pain, rashes or other concerns <input type="checkbox"/> Protheses - remove for sleeping, careful daily washing if skin contact; review with GP if symptoms of urinary tract infection (burning, stinging or blood in urine) or skin irritation <input type="checkbox"/> Discuss with Dr any treatment concerns/ needs
<p>Gender incongruence - psychological aspects</p> <p><i>Reference: Pride in Sport Australia, cited Nov. 2016</i></p> <p>Other causes of mental distress:</p> <ul style="list-style-type: none"> - Depression - Anxiety - Other mental health disorder: 	<p>Identification & appropriate management of any mental distress caused by gender incongruence, esp. if persistent despite gender affirmation, in order to improve symptom control and quality of life</p> <p>Identification & appropriate management of any co-morbid mental health disorder to achieve & maintain symptom control & improve QOL</p>	<p>Other health care providers:</p> <p>Results:</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Regular review with GP <input type="checkbox"/> Psychotherapy with psychologist if appropriate <input type="checkbox"/> Online resources: https://headtohealth.gov.au/ www.acon.org.au <input type="checkbox"/> Establish/ maintain healthy sleep habits <input type="checkbox"/> Healthy diet, consider dietician review <input type="checkbox"/> 30 mins(+) moderate intensity exercise daily, consider exercise physiology <input type="checkbox"/> Meditation/ mindfulness as appropriate <input type="checkbox"/> Discuss with Dr any med side effects or concerns <input type="checkbox"/> Lifeline: 13 11 14

OTHER CHRONIC CARE MANAGEMENT PLAN

Health Care Need/ Issue/ Condition	Management Goals	OTHER care providers Results/ appointments	ACTION ("TO DO") LIST:
<p>FOR EXAMPLE</p> <p>Diabetes Mellitus (Poor glucose control increases risk of cardiovascular, kidney and eye disease and nerve damage)</p> <p><i>Reference: RACGP General practice management of type 2 diabetes 2016-18</i></p>	<p>Achieve glycaemic control with diet, exercise and medications (where appropriate) to prevent development or progression of diabetic complications</p> <p>Regular multidisciplinary team assessment for the prevention/ early detection of diabetic complications</p> <p>Standard targets: HbA1c < 7%/ 53 mmol/mol Total chol. <4.0, HDL ≥1.0, LDL <2.0, non-HDL <2.5, TGs<2.0 BP < 140/90 (< 130/80 if proteinuria) Urine Alb:Cr <3.5 women, <2.5 men</p>	<p>Other health care providers:</p> <p>Results:</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Regular review with GP 3 monthly <input type="checkbox"/> Healthy diet, consider dietician review <input type="checkbox"/> Group allied health services for T2DM <input type="checkbox"/> Diabetes educator, if appropriate <input type="checkbox"/> Skin / skin cancer check <input type="checkbox"/> 30 mins moderate intensity exercise daily (or more) <input type="checkbox"/> Smoking cessation if smoker <input type="checkbox"/> Limit alcohol intake (≤2 standard drinks daily, at least 2 alcohol free days per week) <input type="checkbox"/> Foot check: at least yearly <input type="checkbox"/> Eye check: at least yearly <input type="checkbox"/> Discuss with Dr any med side effects or concerns

PREVENTATIVE HEALTH CARE PLAN

Health Care Need/ Issue/ Condition	Management Goals	ACTION ("TO DO") LIST:
Sexual Health	Determination of sexual health risk & provision of individualised risk reduction strategies & screening plan	<ul style="list-style-type: none"> <input type="checkbox"/> Use of appropriate protection with any new, untested sexual partners <input type="checkbox"/> PrEP, if appropriate <input type="checkbox"/> STI screening recommendations (see www.stguidelines.org.au): <input type="checkbox"/> See your doctor if any genital or sexual symptoms
Eye Health	Prevention and early detection of eye disease	<ul style="list-style-type: none"> <input type="checkbox"/> Eye check with optometrist at least every 2 years (more frequently as recommended) <input type="checkbox"/> Report any sudden change in vision or any concerns about your vision
Oral Health	Maintenance of good oral hygiene for the prevention and early detection of dental disease	<ul style="list-style-type: none"> <input type="checkbox"/> Yearly dental checks, or more frequently if advised <input type="checkbox"/> Brushing teeth twice a day with fluoride toothpaste & daily flossing <input type="checkbox"/> Smoking cessation if smoker <input type="checkbox"/> Avoid sugary snacks and drinks <p>Dentist (if any): Last dental check:</p>

Health Care Need/ Issue/ Condition	Management Goals	ACTION (“TO DO”) LIST:
Skin Health	<p>Early detection and removal of skin cancers</p> <p>Maintenance of good skin integrity</p>	<p><input type="checkbox"/> Consider yearly skin checks with GP</p> <p><input type="checkbox"/> Be aware of changes in your skin; if any new or changing skin lesions see your GP</p> <p><input type="checkbox"/> Be ‘sun smart’ by wearing hats, protective clothing, sunglasses and sunscreen (reapply every 2 hrs) www.sunsmart.com.au</p>
Preventative Health & Screening	<p>Achieve and maintain best possible physical and mental health, maintain independence and prevent disease through health diet, regular exercise, not smoking, limiting alcohol intake and appropriate screening</p> <p>Vaccinations attended:</p> <p>Screening attended:</p> <p>Outstanding:</p>	<p><input type="checkbox"/> Aggressive cardiovascular disease management through lifestyle measures (listed below) & medication where appropriate</p> <p><input type="checkbox"/> Smoking cessation if smoker</p> <p><input type="checkbox"/> Regular exercise - MINIMUM 30 mins moderate intensity 5+ days/ wk</p> <p><input type="checkbox"/> Health diet high in (non-starchy) vegies, unrefined grains & moderate healthy fats</p> <p><input type="checkbox"/> Limit alcohol in take (≤ 2 standard drinks daily, at least 2 alcohol free days per week)</p> <p><i>Vaccination:</i></p> <p><input type="checkbox"/> Influenza (flu) – annually</p> <p><input type="checkbox"/> Whooping cough/ tetanus – every 10 years</p> <p><input type="checkbox"/> Pneumococcal – at age 65 (or younger if high risk)</p> <p><input type="checkbox"/> Shingles – at age 70</p> <p><input type="checkbox"/> Hep A & meningococcal, if appropriate</p> <p><input type="checkbox"/> Vaccination recommended prior to travel</p> <p><i>Cancer screening:</i></p> <p><input type="checkbox"/> Cervical cancer: screening ages 25-74 At least every 5 yrs (if last test after Dec 2017 - 2yrs if below), more frequently as advised; see Dr if abnormal vaginal bleeding</p> <p><input type="checkbox"/> Breast cancer: Mammogram every 2 years ages 50-74 years BreastScreen NSW: 13 20 50</p> <p><input type="checkbox"/> Skin cancer: skin check annually if risk factors such as family history or sunburns</p> <p><input type="checkbox"/> Bowel cancer: poo test for blood 2 yearly from age 50, colonoscopy if appropriate</p>

Template created 2019 by Dr Holly Inglis.. Recommendations based on the RACGP Guidelines for Preventative Activities in General Practice 9th Edition, 2016 unless otherwise stated.

TEAM CARE ARRANGEMENT for <insert patient name>

Team Care Arrangement: ____ / ____ / ____ (date of service) Team Care Arrangement reviews: ____ / ____ / ____ (date of service)

Collaborating providers & details (as listed in GPMP)	Treatment / Service Provided	Health Care Need/ Issue/ Condition (to be) addressed by provider	Treatment / Service Goals & Actions for
Practice nurses NB to Drs: Nurses to not qualify as 'collaborating providers' for the TCA	Nursing care	LIST CONDITION	SERVICES THE PRACTICE NURSES WILL PROVIDE - e.g. wt checks, needs to be included to be able to claim 10997
1. Collaborating provider:			
2. Collaborating provider:			
Other collaborating providers:			

Signed copies of this final page to be forwarded to collaborating providers

For collaborating providers - please fax back to _____, if any changes suggested to current team care arrangements

PATIENT CONSENT FOR GPMP/TCA

I, **<insert patient name>**, acknowledge that:

- My doctor has explained to me (and/or my carer) the purpose of & the steps involved in preparing my care plan & I have agreed to the preparation of the plan
- My doctor has discussed with me & we have agreed upon management goals for my health care which will be reviewed regularly
- My doctor has offered me (and/or my carer) a copy of my health care plan

If a team care arrangement has been undertaken:

- My doctor has explained the steps involved the development of the team care arrangements to me (and/or my carer)
 - My doctor has discussed with me the collaborating providers in my team care arrangement, their services & treatments, & I agree to my team care arrangement
 - I agree to the involvement of other care providers and to for them to share clinical information without restrictions
 - My doctor has offered me (and/ or my carer) a copy of my team care arrangement
-

<insert patient name>
signature:

____/____/_____

<insert doctor name>
signature:

____/____/_____