Gender Dysphoria Treatment Plan

Client Information	
Name:	
Age:	
Gender Identity:	
Date of Initial Assessment:	

Health Background

Brief medical history:

Any past or current treatments related to gender dysphoria:

Current medications and dosages:

Any other relevant mental health diagnoses:

Treatment Plan

Goals:

Gender Dysphoria Treatment Plan

Treatment Plan
Interventions:
Timeline:
Referral:

Client signature and date: