



QUESTIONNAIRE FOR PROVIDERS FOR TRANSGENDER MEMBERS

IEHP would like to identify Practitioners who have experience and interest in providing high quality care to Transgender members. Please complete the following survey if you would like to be listed in our Provider Directory, as a Practitioner available to our Transgender members.

Practitioner Name	License	NPI
1. Please assess your ability in providing high quality care to Transgender Members: <input type="checkbox"/> No Experience <input type="checkbox"/> Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Advanced		
2. Approximately how many Transgender patients have you cared for in the past twelve (12) months? <input type="checkbox"/> None <input type="checkbox"/> 1 – 2 <input type="checkbox"/> 3 – 9 <input type="checkbox"/> 10 – 25 <input type="checkbox"/> Over 26		
3. How long have you been providing care to Transgender patients? <input type="checkbox"/> Under 1 year <input type="checkbox"/> 1 – 5 years <input type="checkbox"/> 6 – 9 years <input type="checkbox"/> Over 10 years		
4. What training, if any, have you received to treat Transgender patients. <i>(Please provide documentation for all that apply)</i> <input type="checkbox"/> Continuing Medical Education (CME) events. <input type="checkbox"/> Other <input type="checkbox"/> Transgender Certifications through WPATH <input type="checkbox"/> None <input type="checkbox"/> Member of World Professional Association for Transgender Health (WPATH)		
5. Please provide evidence of the following annual staff training on Transgender Care, that includes: <input type="checkbox"/> Agenda <input type="checkbox"/> Sign in Sheet <input type="checkbox"/> Policies and Procedures		

Please identify your skill level for the Transgender Service(s) below:

	No Experience	Minimal	Moderate	Advanced
1. Feminizing Mammoplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Male Chest Reconstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Mastectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Gender-Confirming Facial Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Oophorectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Penectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Orchiectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Feminizing Genitoplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Metoidioplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Phalloplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Scrotoplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Voice Masculinization or Feminization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Hormone Therapy Related to Gender Dysphoria or Intersex Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Gender-affirming gynecological care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Voice Therapy Related to Gender Dysphoria or Intersex conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>