

FAA Gender Dysphoria Mental Health Status Report

(Updated 1/29/16)

Name _____

Birthdate _____

Applicant ID# _____

PI# _____

The following information must be addressed in the treating provider's evaluation. Evaluation should be performed in accordance with a comprehensive mental health assessment following the [World Professional Association for Transgender Health \(WPATH\) guidelines](#). Submit either this form* or supporting documentation addressing each item to your AME or to the FAA at:

Federal Aviation Administration
Aerospace Medical Certification Division AAM-300
PO Box 26080
Oklahoma City, OK 73125-9914

1. I am a board certified psychiatrist or licensed psychologist AND I meet the criteria for "a qualified mental health professional" per WPATH (current version) guidelines.

<input type="checkbox"/> Yes	<input type="checkbox"/> No-explain
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2. This airman meets the DSM-5 diagnostic criteria for Gender Dysphoria and the condition is not secondary to, or better accounted for, by other diagnoses.

<input type="checkbox"/> Yes	<input type="checkbox"/> No-explain
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3. PSYCHIATRIC HISTORY:
Current mental health diagnosis or coexisting mental health concerns.....

<input type="checkbox"/> None	<input type="checkbox"/> Yes-explain
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Previous mental health diagnosis or coexisting mental health concerns.....

<input type="checkbox"/> None	<input type="checkbox"/> Yes-explain
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ER visit or hospitalization for any psychiatric illness or condition ever.....

<input type="checkbox"/> None	<input type="checkbox"/> Yes-explain
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Any suicide attempt(s) ever.....

<input type="checkbox"/> None	<input type="checkbox"/> Yes-explain
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Substance Use disorder per DSM-5.....

<input type="checkbox"/> None	<input type="checkbox"/> Yes-explain
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(e.g. alcohol, cannabis, stimulants, hallucinogens, opioids)

4. PSYCHIATRIC TREATMENT: (List start and end dates on each. For medications, also note name, dose, and side effects, if any.)
Current use.....

<input type="checkbox"/> None	<input type="checkbox"/> Yes-explain
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Previous use.....

<input type="checkbox"/> None	<input type="checkbox"/> Yes-explain
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Psychotherapy for any condition other than GD (e.g. depression, anxiety).....

<input type="checkbox"/> None	<input type="checkbox"/> Yes-explain
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Other treatments (e.g. cognitive therapy, talk therapy, electroconvulsive therapy)

<input type="checkbox"/> None	<input type="checkbox"/> Yes-explain
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5. CURRENT STATUS: Airman is doing well. There are no mental health concerns. Psychotherapy (if any) is for gender dysphoria only. No other treatment is needed (do not include support group or support group counseling).

<input type="checkbox"/> Yes	<input type="checkbox"/> No-explain
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6. Any evidence of cognitive dysfunction or is a formal neuropsychological evaluation indicated?

<input type="checkbox"/> None	<input type="checkbox"/> Yes-explain
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7. Do you have ANY concerns regarding this airman?

<input type="checkbox"/> None	<input type="checkbox"/> Yes-explain
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Treating Provider Signature

Date of Evaluation

Name or Office Stamp

Phone Number

***For any response which requires further explanation, submit supporting documentation. In some cases, actual records will be required.**