Fara Movagharnia DO, FACOS

www.grsatlanta.com / www.srsatlanta.com

Surgery Application

Name:		**Legal Name:**	
Address:			
Phone:		**Email:**	
Birth Date:		**SSN:**	
Height:		**Weight:**	
HIV Status:	☐ **Pos** ☐ **Neg** ☐ **Unknown**	**Smoker:**	☐ **Yes** ☐ **No**

☐ **I want to plan a pre-operative consultation prior to my surgery date.**

☐ **I have concerns about vaginal depth and may require skin graft (MTF)**

1. Criteria for surgery: weight less than 210 lbs and non-smoker, due to increased risk of healing related complications associated with smoking. If you can not meet this criteria, consider postponing your surgery until you can – your recovery will be much easier. Contact Dr. Movagharnia if your date is getting close and you have not been able to quit smoking or lose weight. If you show up in Atlanta not ready, your surgery will be postponed.
2. Legal name required only for Surgical Declaration Letter, which is used to certify permanent and irrevocable SRS/GRS for passport, birth certificate and legal ID where required. The letter will indicate NEW NAME aka LEGAL NAME if appropriate.

Date Hormone Therapy Started:			
Endocrinologist or Physician:		**Name:**	
(if applicable)		**Contact:**	
Real Life Test Started:			
Recent Employment History:			
(optional)			

Primary Relationship(s): (optional)		
In Case of Emergency:	**Name:**	
(required)	**Contact:**	
Letter of Recommendation #1:	**Name:**	
(if known, note that 2 letters are required)	**Contact:**	
Letter of Recommendation #2:	**Name:**	
(if known, note that 2 letters are required)	**Contact:**	

Do you have a target date or timeframe for your surgery?	
Which surgery or surgeries are you applying for?	
If you expect to file a claim with your insurance company, please list company name and contact information.	

- Dr. Movagharnia and the hospital that you will have your surgery at require candidates to meet the requirements set by the HBIGDA Standards of Care
- **Relationship Information** is optional but will help us to be sensitive to your living situation and significant relationship(s).
- We understand that you may not have arranged for **Letters of Recommendation** at the time this application is made. By signing below, you release us to communicate with professionals who have provided or will provide letters of recommendation for your surgery.
- If filing a claim with your insurance company, signing below gives permission to Dr. Bowers' office to communicate with your insurance company regarding the claim.

Please enclose ☐ $1000.00 (personal checks and cashier's check are NOT acceptable) down-payment to reserve a date (non-refundable.

☐ A photograph (so that we can identify you when you show up for your surgery)

☐ Results of an HIV test (performed within 12 weeks of surgery).

Photo Release ☐ Dr. Movagharnia may take photos at the time of surgery for education, website, seminars. I give permission for Dr. Movagharnia to anonymously photograph my surgery. ☐ **Yes** ☐ **No**

CENTER FOR GENDER REASSIGNMENT SURGERY

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