|  | PATIENT I.D. DATA: (Name, DOC#, DOB)   |
| --- | --- |
| **GENDER-AFFIRMING PROPERTY ISSUANCE REQUEST** |
|  |
| Date of request: | Facility: | Unit: |  |
|       |  |       |  |
|  |
|  |
| Item Requested | To be completed by Practitioner: |
| Usage Needs (e.g., times per day, duration per use, etc.) | HSR Needed | Notes |
|       |       | [ ]  |       |
|       |       | [ ]  |       |
|       |       | [ ]  |       |
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|       |       | [ ]  |       |
| PATIENT SIGNATURE |  |
| PRACTITIONER REVIEW COMPLETED BY:(typed/printed name or name stamp)      | DATE      |  |
|  |  |
| After Practitioner review and completion, email form to Captain. |
| CAPTAIN REVIEW |
| Comments (e.g., adjustments, coordination needed, etc.):      |
| CAPTAIN REVIEW COMPLETED BY (typed/printed name):      | DATE      |  |
|  |  |
| After Captain review and completion, email form to Practitioner above. |
| FINAL PRACTITIONER REVIEW/APPROVAL |
| The following requested item(s) are approved: (Order and route to Property for logging and distribution)      |
| The following requested item(s) are not approved: (Comments required for each item.)      |
| Comments:      |
| PRACTITIONER:(typed/printed name or name stamp)      | SIGNATUREClick or tap here to enter text. | DATE      |
| Distribution: **ORIGINAL** – Health Record **COPY** – Property, Patient, HSM, CUS |