



Puberty Blockers: Informed Consent Checklist

What ACON Health Centre Limited (trading as Kaleido Health Centre) should have disclosed but didn't

This checklist shows the information that should be disclosed before starting puberty blocker treatment. **None of this information appears on Kaleido Health Centre's public website.**

Based on the Kaleido Health Centre Informed Consent Compliance Audit (May 2026) conducted by Active Watchful Waiting Inc.

1. Intended effect: suppression of normal pubertal progression

Question: Does the clinic clearly explain that puberty blockers suppress normal pubertal progression, that this is the intended physiological effect, and that downstream developmental effects may not be fully reversible even if puberty resumes after cessation?

Why this matters: The central intended effect of pubertal treatment (puberty blockers) which must be clearly explained so parents and minors understand that normally timed puberty is being medically interrupted, not merely 'paused' in a neutral sense. Consumers also need to understand that while pubertal development may resume after stopping, some downstream developmental effects may not be fully reversible.

2. Hot flashes, fatigue, headaches, mood changes (drug effects)

Question: Does the clinic disclose common or plausible short-term drug effects of GnRHa treatment, including hot flashes, fatigue, headaches, mood changes, and the limits of available frequency data in gender dysphoria cohorts?

Why this matters: Short-term adverse effects affect day-to-day wellbeing, tolerability, adherence, and the need for monitoring or treatment adjustment. Even where frequency is uncertain in 'gender dysphoria' cohorts, known drug effects should not be omitted from consent materials. i.e. Lupron is a drug commonly used to castrate male prisoners - is and has been used on young children. Good to know? You tell me.

3. Growth velocity changes, height progression not matching expected growth

Question: Does the clinic disclose that puberty blockers may affect growth velocity, height progression, skeletal maturation, and that reversibility or catch-up may depend on timing, treatment duration, and subsequent hormone use?

Why this matters: Growth effects are material to informed consent because puberty suppression occurs during a time-sensitive developmental period when height, growth velocity, and skeletal maturation are changing rapidly. Families may assume blockers merely delay puberty without understanding potential effects on growth trajectory. Remember puberty suppression for gender-related distress is not merely a short-term symptom intervention. It occurs during a time-sensitive developmental period and may affect growth, bone development, fertility potential, sexual maturation, neurocognitive development, mental health assessment, and later treatment pathways. Where evidence is limited or uncertain, that uncertainty is itself material to informed consent. You need to know up front.

4. Bone mineral density accrual reduced during treatment

Question: Does the clinic disclose bone density risks, reduced bone mineral accrual during treatment, uncertainty about long-term recovery, and the proposed monitoring plan?

Why this matters: Bone density accrual is one of the most consistently identified risk domains. Bone mineral increase that occurs in childhood and adolescence influences long term bone health and is associated with fracture risk in adulthood. It is material because adolescence is a critical period for building peak bone mass, and long-term recovery remains uncertain.

5. Long-term bone after blockers followed by long-term hormones

Question: Does the clinic disclose that long-term bone outcomes after blockers followed by cross-sex hormones remain uncertain and may differ depending on subsequent hormone exposure, including possible persistent deficits in some groups?

Why this matters: This is material because many patients do not use blockers as an isolated intervention but proceed to cross-sex hormones. Long-term bone outcomes may differ depending on sex, age at commencement, duration of pubertal

suppression, and subsequent hormone regimen. Patients and parents therefore need to understand not only the risks of blockers alone, but the possible cumulative effects of the full treatment pathway.

6. Fracture risk / osteoporosis later in life

Question: Does the clinic disclose that long-term fracture and osteoporosis risks are unknown due to lack of robust long-term follow-up, and that reduced peak bone mass may have later-life implications?

Why this matters: Bone mass built during adolescence helps determine skeletal strength across the lifespan. If puberty blockers reduce peak bone mass, the consequences may not be visible immediately but could affect later fracture risk or osteoporosis vulnerability. Because these outcomes may take decades to emerge, the lack of robust long-term fracture data is itself a material uncertainty that families should be told about.

7. Cardiometabolic changes (BP, lipids, body composition)

Question: Does the clinic disclose possible cardiometabolic changes, including blood pressure, lipids, body composition, and uncertainty about long-term cardiometabolic outcomes?

Why this matters: Puberty helps shape a child's future heart and metabolic health - including weight distribution, muscle and fat development, blood pressure, and cholesterol. If puberty is paused and later followed by cross-sex hormones, parents need to understand that the long-term effects on these areas are still uncertain. 'We do not yet know enough' is important information for consent.

8. Renal/liver function and diabetes onset

Question: Does the clinic explain that available evidence has not established clear renal, liver, or diabetes effects, but that the evidence is limited and does not prove long-term safety?

Why this matters: Parents may hear 'no evidence of harm' and think it means 'proven safe.' But those are not the same thing. With puberty blockers, the evidence on kidney, liver, and diabetes outcomes is still limited, so families should be told that long-term safety has not been firmly established.

9. Neurocognitive development

Question: Does the clinic disclose uncertainty regarding neurocognitive development, brain maturation, and the lack of high-quality long-term cognitive outcome data?

Why this matters: Puberty happens at the same time as major brain development. This includes changes that affect learning, emotions, judgement, and decision-making. If treatment pauses puberty, parents should be told that we do not yet have strong long-term evidence showing what this means for brain development. 'We do not know enough yet' is important information for informed consent.

10. Psychological outcomes (depression/anxiety/suicidality)

Question: Does the clinic disclose the uncertainty of psychological outcome evidence, including depression, anxiety, suicidality, and the limits of observational or biased studies?

Why this matters: If parents are told that blockers may improve a child's mental health, they need to know whether that claim is well proven. For outcomes like depression, anxiety, and suicide risk, the evidence may be limited or uncertain. Parents should be told clearly: what is known, what is not known, and whether the claimed benefits are supported by strong evidence.

11. Gender-related distress (core dysphoria outcome)

Question: Does the clinic disclose whether puberty blockers have been shown to reduce gender-related distress, and explain the evidence limitations where direct measurement or long-term data are weak?

Why this matters: If blockers are being offered to reduce a child's distress about their sexed body, parents need to know whether that benefit has actually been shown. If the evidence is weak or does not directly measure that distress, then parents should be told: this treatment is being offered for a purpose that has not been strongly proven.

12. Fertility preservation feasibility (Female)

Question: Does the clinic disclose fertility preservation uncertainty for female minors, including the lack of robust evidence, time-sensitivity of reproductive development, and possible irreversible infertility if blockers are followed by later medical or surgical interventions?

Why this matters: A girl may not be able to make eggs available for preservation if her reproductive system has not fully matured. If puberty is blocked and later treatment affects her ovaries, uterus, or reproductive function, she may lose the chance to have biological children in the future. Parents, girls, and young women need to know this risk is uncertain, time-sensitive, and potentially permanent.

13. Fertility preservation feasibility (Male)

Question: Does the clinic disclose that male fertility preservation may not be feasible before spermatogenesis, that options may depend on pubertal stage, and that later interventions may make infertility irreversible?

Why this matters: A boy may not yet be producing sperm when puberty blockers are started. If sperm production has not begun, standard fertility preservation may not be possible at that time. If blockers are then followed by cross-sex hormones or surgery, he may lose the chance to develop or preserve fertility later. In some cases, this could mean permanent infertility. Families should be told clearly that fertility options may depend on the child's stage of puberty, and that 'fertility preservation' may not be available or reliable before sperm production has started.

14. Sexual maturation and later sexual function

Question: Does the clinic disclose possible impacts on sexual maturation, genital development, libido, orgasmic function, adult sexual function, and the lack of robust long-term sexual-function data?

Why this matters: Puberty is when the body develops sexually. This includes genital development, sexual feelings, libido, capacity for orgasm, and later adult sexual function. If puberty is paused during this stage, families should be told that the long-term effects on sexual development and adult sexual function are not well understood. These are sensitive and deeply personal outcomes, so uncertainty should be explained clearly before treatment begins. In particular, that loss of sexual function has been an outcome.

15. Downstream surgical implications due to limited genital tissue after early blockade (Male)

Question: Does the clinic disclose that early puberty suppression in males may limit genital tissue development and may affect later surgical options, techniques, complexity, or outcomes?

Why this matters: Some later surgeries may require enough genital tissue to work with. If blockers are started before that tissue has developed, surgery may be more difficult or may require different techniques. Families need to know that choices made early in puberty may affect surgical options later in life. (In plain English the penis will be too small to invert into a pseudo vagina later in life.)

16. Social/legal impacts (minors): parental consent, capacity assessment, court involvement in some jurisdictions

Question: Does the clinic clearly disclose parental/guardian consent requirements, capacity assessment processes, and whether court or tribunal involvement may be required where there is dispute about diagnosis, treatment, or capacity?

Why this matters: Children and teenagers are not able to consent to medical treatment in the same way adults can. Parents need to be involved, and clinicians need to assess whether the young person has enough maturity and understanding to make the decision. If parents disagree, or if there is disagreement about the child's diagnosis, capacity, or treatment pathway, the matter may need legal advice or court/tribunal involvement. Families should be told this clearly before they enter the treatment pathway.

Source: Active Watchful Waiting Inc. | Kaleido Health Centre Informed Consent Compliance Audit (May 2026)

Download the full audit and AHPRA notification: aww.org.au/informed-consent

TABLE 1: PUBERTY BLOCKERS CONSEQUENCES BY DOMAIN

Note: These domains are included because puberty suppression for gender-related distress is not merely a short-term symptom intervention. It occurs during a time-sensitive developmental period and may affect growth, bone development, fertility potential, sexual maturation, neurocognitive development, mental health assessment, and later treatment pathways. Where evidence is limited or uncertain, that uncertainty is itself material to informed consent.

(Evidence-quality labels: High / Moderate / Low / Very low (GRADE-like). Where incidence is unavailable, it is marked unknown and the reason is stated.)

The following tables are Colour coded for compliance to the ‘Checklist item derived’ column, as found by audit:

Yes No Partial/Unclear

<i>Disclosure Domain</i>	<i>Why material to consent</i>	<i>Typical timeline</i>	<i>Reversibility</i>	<i>Estimated frequency (or range)</i>	<i>Evidence quality</i>	<i>Checklist item derived</i>	<i>Key citations</i>
<i>Intended effect: suppression of pubertal progression</i>	<i>This is the central intended effect of treatment and must be clearly explained so parents and minors understand that normally timed puberty is being medically interrupted, not merely “paused” in a neutral sense. Consumers also need to understand that while pubertal development may resume after stopping, some downstream developmental effects may not be fully reversible.</i>	<i>Short (weeks–months)</i>	<i>Typically reversible after cessation (puberty can resume), but downstream developmental effects may not be fully reversible</i>	<i>High likelihood physiologic suppression in most patients</i>	<i>Moderate–High</i>	<i>Does the clinic clearly explain that puberty blockers suppress normal pubertal progression, that this is the intended physiological effect, and that downstream developmental effects may not be fully reversible even if puberty resumes after cessation?</i>	[01]
<i>Hot flashes, fatigue, headaches, mood changes (drug effects)</i>	<i>Short-term adverse effects are material because they affect day-to-day wellbeing, tolerability, adherence, and the need for monitoring or treatment adjustment. Even where frequency is uncertain in gender dysphoria cohorts, known drug effects should not be omitted from consent materials.</i>	<i>Short</i>	<i>Reversible when stopped</i>	<i>Unknown in GD cohorts (harms inconsistently and non-standard reporting); common adverse effects known from GnRHα use generally</i>	<i>Low (in GD cohorts)</i>	<i>Does the clinic disclose common or plausible short-term drug effects of GnRHα treatment, including hot flashes, fatigue, headaches, mood changes, and the limits of available frequency data in gender dysphoria cohorts?</i>	[02]

Disclosure Domain	Why material to consent	Typical timeline	Reversibility	Estimated frequency (or range)	Evidence quality	Checklist item derived	Key citations
<i>Growth velocity changes; height progression not matching expected growth</i>	<i>Growth effects are material because puberty suppression occurs during a time-sensitive developmental period when height, growth velocity, and skeletal maturation are changing rapidly. Families may assume blockers merely delay puberty without understanding potential effects on growth trajectory.</i>	<i>Med.</i>	<i>Partly reversible/uncertain (depends on timing, duration, subsequent hormones)</i>	<i>Reported in multiple studies; precise incidence varies; comparative data limited</i>	<i>Moderate (directional signal), Low (quantification)</i>	<i>Does the clinic disclose that puberty blockers may affect growth velocity, height progression, skeletal maturation, and that reversibility or catch-up may depend on timing, treatment duration, and subsequent hormone use?</i>	[03]ⁱⁱⁱ
<i>Bone mineral density accrual reduced during treatment</i>	<i>Bone density accrual is one of the most consistently identified risk domains. It is material because adolescence is a critical period for building peak bone mass, and long-term recovery remains uncertain.</i>	<i>Med.</i>	<i>Uncertain; may partially recover after cessation and/or subsequent hormones; depends on age at start and subsequent regimen</i>	<i>Multiple studies report reductions; magnitude varies; fracture outcomes unknown. Recent studies show mixed recovery with GAHT; persistent deficits possible in some."</i>	<i>Moderate (consistent signal), Low (long-term outcomes)</i>	<i>Does the clinic disclose bone density risks, reduced bone mineral accrual during treatment, uncertainty about long-term recovery, and the proposed monitoring plan?</i>	[04]^{iv}
<i>Long-term bone outcomes after blockers followed by long-term hormones</i>	<i>This is material because many patients do not use blockers as an isolated intervention but proceed to cross-sex hormones. Long-term bone outcomes may differ depending on sex, age at commencement, duration of suppression, and subsequent hormone regimen.</i>	<i>Long</i>	<i>Uncertain; not fully reversible once peak bone mass window passes</i>	<i>In a cohort of 75 who used blockers <18 then ≥9 years hormones: lumbar spine z-score remained lower in males receiving oestrogen, while most sites caught up in females receiving testosterone</i>	<i>Low (single-centre cohort with selection/loss-to-follow-up concerns)</i>	<i>Does the clinic disclose that long-term bone outcomes after blockers followed by cross-sex hormones remain uncertain and may differ depending on subsequent hormone exposure, including possible persistent deficits in some groups?</i>	[05]^v

Disclosure Domain	Why material to consent	Typical timeline	Reversibility	Estimated frequency (or range)	Evidence quality	Checklist item derived	Key citations
<i>Fracture risk / osteoporosis later in life</i>	<i>Even where robust long-term fracture data are absent, the absence of evidence is itself material because fracture and osteoporosis outcomes may take decades to emerge. Families should know that long-term skeletal outcomes are not yet well established.</i>	<i>Long</i>	<i>Potentially irreversible if peak bone mass reduced</i>	<i>Unknown: no robust long-term fracture data in adolescents treated for GD; requires decades of follow-up</i>	<i>Very low</i>	<i>Does the clinic disclose that long-term fracture and osteoporosis risks are unknown due to lack of robust long-term follow-up, and that reduced peak bone mass may have later-life implications?</i>	[06]^{vi}
<i>Cardiometabolic changes (BP, lipids, body composition)</i>	<i>Cardiometabolic effects are material because puberty and sex hormones influence body composition, metabolism, blood pressure, and lipid profiles. Mixed or limited evidence should be disclosed as uncertainty rather than reassurance.</i>	<i>Med.</i>	<i>Often reversible/partly reversible, but long-term risk unknown</i>	<i>Mixed findings across studies; no clear evidence for diabetes onset; heterogeneity high</i>	<i>Low</i>	<i>Does the clinic disclose possible cardiometabolic changes, including blood pressure, lipids, body composition, and uncertainty about long-term cardiometabolic outcomes?</i>	[07]^{vii}
<i>Renal/liver function and diabetes onset</i>	<i>This is material because “no evidence of effect” may reflect limited data and short follow-up rather than proven safety. Consent should distinguish between evidence showing no harm and insufficient evidence to detect harm.</i>	<i>Med.</i>	<i>Reversible if present</i>	<i>Evidence brief found no evidence of effect on renal/liver function or diabetes onset, but this largely reflects limited data and follow-up</i>	<i>Low</i>	<i>Does the clinic explain that available evidence has not established clear renal, liver, or diabetes effects, but that the evidence is limited and does not prove long-term safety?</i>	[08]^{viii}
<i>Neurocognitive development</i>	<i>Neurocognitive development is material because puberty occurs alongside major brain maturation. Where systematic reviews report insufficient or inconsistent evidence, families need to know that cognitive and neurodevelopmental effects are not well established.</i>	<i>Long</i>	<i>Unknown</i>	<i>Systematic reviews report insufficient/inconsistent evidence; no high-quality studies for key cognitive endpoints</i>	<i>Very low</i>	<i>Does the clinic disclose uncertainty regarding neurocognitive development, brain maturation, and the lack of high-quality long-term cognitive outcome data?</i>	[09]^x

Disclosure Domain	Why material to consent	Typical timeline	Reversibility	Estimated frequency (or range)	Evidence quality	Checklist item derived	Key citations
<i>Psychological outcomes (depression/anxiety/suicidality)</i>	<i>Psychological outcomes are central to consumer decision-making because treatment is often sought or justified on mental health grounds. It is material that evidence may be low quality, mixed, biased, or insufficient to establish reliable benefit.</i>	<i>Med.</i>	<i>Unknown; may improve or worsen depending on individual factors</i>	<i>NZ brief reports “significant improvement” in some outcomes but rates evidence low with high bias; other reviews find inconsistent/no robust evidence</i>	<i>Low</i>	<i>Does the clinic disclose the uncertainty of psychological outcome evidence, including depression, anxiety, suicidality, and the limits of observational or biased studies?</i>	[10]^x
<i>Gender-related distress (core dysphoria outcome)</i>	<i>This is material because reducing gender-related distress is usually the main stated purpose of treatment. If few studies directly measure this outcome, or evidence is very low certainty, that limitation must be disclosed.</i>	<i>Med.–Long</i>	<i>Unknown</i>	<i>Few studies directly measure; evidence insufficient for firm conclusions</i>	<i>Very low</i>	<i>Does the clinic disclose whether puberty blockers have been shown to reduce gender-related distress, and explain the evidence limitations where direct measurement or long-term data are weak?</i>	[11]^{xi}
<i>Fertility preservation feasibility (Female)</i>	<i>Fertility preservation is material because suppression may occur before full reproductive maturation, and later interventions may make infertility permanent. If there are no studies on fertility preservation feasibility for females receiving GnRHα in this context, that uncertainty must be disclosed.</i>	<i>Med.</i>	<i>Irreversible if gonadal maturation prevented and later gonadectomy occurs</i>	<i>NZ evidence brief identified no studies on fertility preservation for females receiving GnRHα in this context</i>	<i>Very low</i>	<i>Does the clinic disclose fertility preservation uncertainty for female minors, including the lack of robust evidence, time-sensitivity of reproductive development, and possible irreversible infertility if blockers are followed by later medical or surgical interventions?</i>	[12]^{xii}
<i>Fertility preservation feasibility (Male)</i>	<i>This is material because sperm production may not have commenced before blockers are started. If spermatogenesis never develops and treatment progresses to later interventions, fertility loss may become irreversible.</i>	<i>Med.</i>	<i>Irreversible if spermatogenesis never develops and later gonadectomy occurs</i>	<i>Evidence exists for surgical sperm retrieval attempts in some settings, but overall feasibility depends on pubertal development stage and prior blockers</i>	<i>Low</i>	<i>Does the clinic disclose that male fertility preservation may not be feasible before spermatogenesis, that options may depend on pubertal stage, and that later interventions may make infertility irreversible?</i>	[13]^{xiii}

<i>Disclosure Domain</i>	<i>Why material to consent</i>	<i>Typical timeline</i>	<i>Reversibility</i>	<i>Estimated frequency (or range)</i>	<i>Evidence quality</i>	<i>Checklist item derived</i>	<i>Key citations</i>
<i>Sexual maturation and later sexual function</i>	<i>Sexual development is material because puberty contributes to genital development, sexual maturation, libido, orgasmic function, and adult sexual capacity. Sparse long-term data and possible sensitive developmental windows make this a core consent issue.</i>	<i>Long</i>	<i>Likely partly irreversible if typical pubertal sexual development is blocked during sensitive developmental windows</i>	<i>Systematic review/meta-analysis coverage notes missing data for sexual dysfunction outcomes; long-term sexual function data are sparse</i>	<i>Very low</i>	<i>Does the clinic disclose possible impacts on sexual maturation, genital development, libido, orgasmic function, adult sexual function, and the lack of robust long-term sexual-function data?</i>	[14]^{xiv}
<i>Downstream surgical implications due to limited genital tissue after early blockade (Male)</i>	<i>This is material because early blockade may affect genital tissue development, which can later influence surgical options, surgical complexity, or outcomes. Consumers may not realise that an early “pause” can affect later surgical feasibility.</i>	<i>Long</i>	<i>Not reversible once development window passes</i>	<i>Quantified incidence unknown; raised as a clinical concern in multiple reviews and safety discussions</i>	<i>Low</i>	<i>Does the clinic disclose that early puberty suppression in males may limit genital tissue development and may affect later surgical options, techniques, complexity, or outcomes?</i>	[15]^{xv}
<i>Social/legal impacts (minors): parental consent, disputes, court involvements in some jurisdictions</i>	<i>Legal and consent issues are material because minors may require parental involvement, capacity assessment, or court/tribunal pathways where there is disagreement. Families need to understand the legal framework before engaging treatment pathways.</i>	<i>Short–Med.</i>	<i>Not applicable</i>	<i>Jurisdiction-dependent; can be high-impact</i>	<i>Moderate (legal documentation exists), varies by place</i>	<i>Does the clinic clearly disclose parental/guardian consent requirements, capacity assessment processes, and whether court or tribunal involvement may be required where there is dispute about diagnosis, treatment, or capacity?</i>	[16]^{xvi}

Audit use: The checklist items derived from this table are not intended to prove that each outcome will occur. They identify material risk and uncertainty domains that a reasonable consumer, parent, or minor would need disclosed before deciding whether to engage a clinic offering puberty suppression or onward gender-affirming medical pathways.

REFERENCES:

-
- ⁱJo Taylor, Alex Mitchell, Ruth Hall et al., 'Interventions to Suppress Puberty in Adolescents Experiencing Gender Dysphoria or Incongruence: A Systematic Review', *Archives of Disease in Childhood*, 2024, <https://doi.org/10.1136/archdischild-2023-326669>, PDF available at White Rose Research Online: <https://eprints.whiterose.ac.uk/id/eprint/211412/1/archdischild-2023-326669.full.pdf>
- ⁱⁱ Taylor et al., 'Interventions to Suppress Puberty', 2024 <https://eprints.whiterose.ac.uk/id/eprint/211412/1/archdischild-2023-326669.full.pdf>
- ⁱⁱⁱ Taylor et al., 'Interventions to Suppress Puberty', 2024 <https://eprints.whiterose.ac.uk/id/eprint/211412/1/archdischild-2023-326669.full.pdf>
- ^{iv} Taylor et al., 'Interventions to Suppress Puberty', 2024 <https://eprints.whiterose.ac.uk/id/eprint/211412/1/archdischild-2023-326669.full.pdf>
- ^v Maria Anna Theodora Catharina van der Loos, Mariska Caroline Vlot, Daniel Tatting Klink et al., 'Bone Mineral Density in Transgender Adolescents Treated With Puberty Suppression and Subsequent Gender-Affirming Hormones', *JAMA Pediatrics*, vol. 177, no. 12, 2023, pp. 1332–1341, <https://doi.org/10.1001/jamapediatrics.2023.4588>, PubMed: <https://pubmed.ncbi.nlm.nih.gov/37902760/>
- ^{vi} <https://eprints.whiterose.ac.uk/id/eprint/211412/1/archdischild-2023-326669.full.pdf>
- ^{vii} Ministry of Health. 2024. Impact of Puberty Blockers in Gender-Dysphoric Adolescents: An evidence brief. Wellington: Ministry of Health. <https://www.health.govt.nz/system/files/2024-11/Impact-of-Puberty-Blockers-in-Gender-Dysphoric-Adolescents-evidence-brief.pdf>
- ^{viii} Ministry of Health. 2024. <https://www.health.govt.nz/system/files/2024-11/Impact-of-Puberty-Blockers-in-Gender-Dysphoric-Adolescents-evidence-brief.pdf>
- ^{ix} Taylor et al., 'Interventions to Suppress Puberty', 2024 <https://eprints.whiterose.ac.uk/id/eprint/211412/1/archdischild-2023-326669.full.pdf>
- ^x Ministry of Health. 2024. <https://www.health.govt.nz/system/files/2024-11/Impact-of-Puberty-Blockers-in-Gender-Dysphoric-Adolescents-evidence-brief.pdf>
- ^{xi} Taylor et al., 'Interventions to Suppress Puberty', 2024 <https://eprints.whiterose.ac.uk/id/eprint/211412/1/archdischild-2023-326669.full.pdf>
- ^{xii} Ministry of Health. 2024. <https://www.health.govt.nz/system/files/2024-11/Impact-of-Puberty-Blockers-in-Gender-Dysphoric-Adolescents-evidence-brief.pdf>
- ^{xiii} Ministry of Health. 2024. <https://www.health.govt.nz/system/files/2024-11/Impact-of-Puberty-Blockers-in-Gender-Dysphoric-Adolescents-evidence-brief.pdf>
- ^{xiv} Anna Miroshnychenko, Yetiani Roldan, Sara Ibrahim et al., 'Puberty Blockers for Gender Dysphoria in Youth: A Systematic Review and Meta-analysis', *Archives of Disease in Childhood*, first published online 24 January 2025, <https://doi.org/10.1136/archdischild-2024-327909>, PDF hosted by the Supreme Court of the United States: https://www.supremecourt.gov/opinions/URLs_Cited/OT2024/23-477/23-477-5.pdf
- ^{xv} Commission on Human Medicines, CHM Advice to SoS and Minister for Health: GnRH Agonists for Pubertal Suppression, 13 November 2024, https://assets.publishing.service.gov.uk/media/678e6994ea48a571517acf98/chm-advice-to-sos-on-gnrh-agonists-for_pubertal-suppression.pdf

^{xvi} NSW Health, 'NSW Specialist Trans and Gender Diverse Health Service', NSW Government, <https://www.health.nsw.gov.au/lgbtiq-health/Pages/tgd-health-service.aspx>