



Feminising Hormones (Oestrogen): 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 oestrogen 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. Expected feminising effects

Question: Does the clinic clearly disclose the expected feminising effects of oestrogen, including breast development, fat redistribution, reduced spontaneous erections, reduced testicular volume, expected timelines, and which effects may be irreversible or only partly reversible?

Why this matters: These are expected treatment effects, but they are not all equally reversible. Breast development may not fully reverse, while sexual and genital effects may be partly reversible or variable. Young people and families need to understand the likely physical changes, expected timelines, and which effects may persist after stopping.

2. Reduced spermatogenesis and infertility risk

Question: Does the clinic disclose reduced spermatogenesis and infertility risk, explain that fertility may not reliably recover after stopping treatment, and offer fertility counselling or preservation discussion before treatment begins?

Why this matters: Oestrogen may reduce sperm production and impair future reproductive options. Although spermatogenesis may return after stopping in some cases, reversibility is not guaranteed and may depend on baseline fertility, duration of treatment, age, and treatment regimen. Parents and young people should not be reassured by vague statements about fertility recovery without understanding the uncertainty and individual risk.

3. Sexual function changes

Question: Does the clinic disclose possible sexual function changes, including libido, erectile function, orgasm intensity, genital function, persistence of effects, and the limited quality of long-term sexual-function data?

Why this matters: Oestrogen may affect libido, erectile function, orgasmic experience, genital function, and sexual wellbeing. These outcomes are personal, clinically significant, and often under-measured in studies. Young people deserve to understand that these changes may occur, that some effects may persist, and that uncertainty about long-term sexual function should be disclosed rather than glossed over.

4. Venous thromboembolism (blood clots)

Question: Does the clinic disclose VTE risk associated with feminising hormone therapy, including known incidence estimates where available, individual risk factors, route/dose considerations, and the need for monitoring or risk mitigation?

Why this matters: VTE (blood clots) is a serious adverse event and a known risk domain for oestrogen exposure. Risk may vary by route (oral vs other), dose, duration, age, smoking, personal or family clotting history, and other health conditions. Families need real risk information where available, not vague reassurance.

5. Ischaemic stroke

Question: Does the clinic disclose possible ischaemic stroke risk, the limits of available evidence, individual risk factors, and how cardiovascular risk is assessed before and during feminising hormone therapy?

Why this matters: Stroke risk is a serious cardiovascular outcome associated with oestrogen exposure in some cohort data. Even where evidence is observational and risk varies by individual factors, it should be disclosed as a potential long-term risk domain. Young people making decisions with lifelong implications need to understand both what is known and what remains uncertain.

6. Myocardial infarction (heart attack)

Question: Does the clinic disclose possible myocardial infarction or broader cardiovascular risks, including uncertainty in the evidence, relevant personal risk factors, and monitoring or referral pathways for elevated cardiovascular risk?

Why this matters: Oestrogen exposure may affect cardiovascular risk profiles. Families need to understand both what is known and what remains uncertain. Disclosure should include that risk estimates may vary by comparison group, regimen, duration, and baseline risk. Proper consent means explaining risks clearly, not hiding behind statistical complexity.

7. Bone health

Question: Does the clinic disclose bone-health considerations for feminising hormone therapy, especially after puberty blockers or gonadectomy, including monitoring of hormone levels, bone density concerns, and uncertainty about long-term outcomes?

Why this matters: Inadequate sex-hormone exposure, prior puberty suppression, removal of gonads, poor adherence, or low oestradiol levels may affect bone density and long-term skeletal outcomes. Families should understand that feminising hormones require monitoring to avoid states where bone health is compromised, and that long-term skeletal outcomes remain uncertain in some contexts.

8. Mood and psychological outcomes

Question: Does the clinic disclose the limits of evidence for mood and psychological outcomes, including that reported benefits may be low-certainty, observational, short-term, or not causally established?

Why this matters: Feminising hormones may be presented or understood as improving depression, anxiety, distress, or wellbeing. Where evidence in young people is low-certainty, observational, or limited, families must understand that improvement is possible but not guaranteed and causality may be uncertain. Young people deserve honest information about the limits of the mental-health evidence before making treatment decisions.

9. Ongoing screening and preventive healthcare

Question: Does the clinic disclose that patients on feminising hormones still require ongoing monitoring and preventive screening based on organs present, including prostate/testicular considerations, breast-health monitoring where relevant, and cardiovascular/metabolic monitoring?

Why this matters: Feminising hormone therapy does not remove the need for organ-specific healthcare. Patients may still require prostate-related care, testicular or genital assessment where relevant, breast-health monitoring depending on exposure and age, and general metabolic and cardiovascular monitoring. Consent should make clear that feminising treatment does not replace ordinary preventive healthcare.

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

From Appendix B of ACCC and AHPRA Audits:

Evidence criteria used to construct the informed consent checklist

This appendix sets out one of the evidence-derived disclosure domains (Feminising Hormones) used to construct the informed consent audit checklist. The purpose is not to provide medical advice or resolve all clinical controversy, but to identify risks, uncertainties, reversibility issues, alternatives, and evidence-quality limitations that are material to informed consumer decision-making. These domains were then converted into checklist questions and tested against Kaleido Health Centre's public-facing materials.

TABLE 2: FEMINISING HORMONES CONSEQUENCES (MALE ON OESTROGEN)

Note: These disclosure domains are included because feminising hormone therapy involves expected physical effects, fertility and sexual-function implications, cardiovascular risk domains, bone-health considerations, psychological-outcome uncertainty, and ongoing screening obligations. Informed consent requires distinguishing intended effects from risks, identifying which effects may persist, and explaining where evidence remains limited or uncertain.

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

Yes	No	Partial/Unclear					
Disclosure Domain	Why material to consent	Typical timeline	Reversibility	Estimated frequency (or range)	Evidence quality	Checklist item derived	Key citations
Intended physical effects (breast development, fat redistribution, reduced spontaneous erections, reduced testicular volume)	<i>These are expected treatment effects, but they are not all equally reversible. Breast development may not fully reverse, while sexual and genital effects may be partly reversible or variable. Consumers need to understand the likely physical changes, expected timelines, and which effects may persist after stopping.</i>	<i>Med.</i>	<i>Many effects partially reversible; breast development often not fully reversible</i>	<i>Common/expected; quantification varies by regimen</i>	<i>Moderate</i>	<i>Does the clinic clearly disclose the expected feminising effects of oestrogen, including breast development, fat redistribution, reduced spontaneous erections, reduced testicular volume, expected timelines, and which effects may be irreversible or only partly reversible?</i>	[17]
Reduced spermatogenesis / infertility risk	<i>Fertility risk is material because oestrogen may reduce sperm production and impair future reproductive options. Although spermatogenesis may return after stopping in some cases, reversibility is not guaranteed and may depend on baseline fertility, duration of treatment, age, and treatment regimen.</i>	<i>Med.</i>	<i>Sometimes reversible after stopping, but not guaranteed; depends on duration and baseline</i>	<i>Unknown population incidence; small cohort shows spermatogenesis may return after cessation</i>	<i>Low–Moderate (mechanistic strong; clinical reversibility data)</i>	<i>Does the clinic disclose reduced spermatogenesis and infertility risk, explain that fertility may not reliably recover after stopping treatment, and offer fertility counselling or preservation discussion before treatment begins?</i>	[18] ⁱⁱ

			fertility		limited)		
Sexual function changes (libido, erectile function, orgasm intensity)	<i>Sexual function is material because oestrogen may affect libido, erectile function, orgasmic experience, genital function, and sexual wellbeing. These outcomes are personal, clinically significant, and often under-measured in studies, so uncertainty should be disclosed rather than glossed over.</i>	Med.	<i>Often partially reversible; may persist</i>	<i>Unknown: infrequently measured with standardised instruments in many cohorts</i>	Low	<i>Does the clinic disclose possible sexual function changes, including libido, erectile function, orgasm intensity, genital function, persistence of effects, and the limited quality of long-term sexual-function data?</i>	[19]ⁱⁱⁱ
Venous thromboembolism (VTE)	<i>VTE is a serious adverse event and a known risk domain for oestrogen exposure. It is material because risk may vary by route, dose, duration, age, smoking, personal/family clotting history, and other comorbidities. Consumers need absolute and relative risk information where available, not vague reassurance.</i>	Med.– Long	<i>Not applicable (event)</i>	<i>In trans-feminine cohort: incidence 5.5 per 1000 person-years; adjusted HR 1.9 vs reference men, 2.0 vs reference women; risk differences increase over time</i>	Moderate (large cohort; observational)	<i>Does the clinic disclose VTE risk associated with feminising hormone therapy, including known incidence estimates where available, individual risk factors, route/dose considerations, and the need for monitoring or risk mitigation?</i>	[20]^v
Ischemic stroke	<i>Stroke risk is material because it is a serious cardiovascular outcome associated with oestrogen exposure in some cohort data. Even where evidence is observational and risk varies by individual factors, it should be disclosed as a potential long-term risk domain.</i>	Long	<i>Not applicable</i>	<i>Incidence 4.8 per 1000 person-years; HR 1.2 vs reference men, 1.9 vs reference women (overall cohort)</i>	Moderate	<i>Does the clinic disclose possible ischemic stroke risk, the limits of available evidence, individual risk factors, and how cardiovascular risk is assessed before and during feminising hormone therapy?</i>	[21]^y

Myocardial infarction	<i>Myocardial infarction is material because oestrogen exposure may affect cardiovascular risk profiles, and consumers need to understand both what is known and what remains uncertain. Disclosure should include that estimates may vary by comparison group, regimen, duration, and baseline risk.</i>	Long	Not applicable	<i>Incidence 2.9 per 1000 person-years; HR 0.9 vs reference men, 1.8 vs reference women (overall cohort)</i>	Moderate	<i>Does the clinic disclose possible myocardial infarction or broader cardiovascular risks, including uncertainty in the evidence, relevant personal risk factors, and monitoring or referral pathways for elevated cardiovascular risk?</i>	[22]^{vi}
Bone health concerns (especially if hypogonadal or low estradiol exposure)	<i>Bone health is material because inadequate sex-hormone exposure, prior puberty suppression, gonadectomy, poor adherence, or low estradiol levels may affect bone density and long-term skeletal outcomes. Consumers should understand that feminising hormones require monitoring to avoid hypogonadal states and protect bone health.</i>	Long	<i>Partly reversible with optimised hormones and lifestyle; depends on adherence and levels</i>	<i>In long-term follow-up after adolescent blockers, lumbar spine z-score remained lower in males receiving estrogen</i>	Low	<i>Does the clinic disclose bone-health considerations for feminising hormone therapy, especially after puberty blockers or gonadectomy, including monitoring of hormone levels, bone density concerns, and uncertainty about long-term outcomes?</i>	[23]^{vii}
Mood and psychological outcomes	<i>Psychological outcomes are material because feminising hormones may be presented or understood as improving depression, anxiety, distress, or wellbeing. Where evidence in young people is low-certainty, observational, or limited, consumers must understand that improvement is possible but not guaranteed and causality may be uncertain.</i>	Med.	Variable	<i>Systematic reviews in <26 show possible depression benefit in one comparative observational study (OR ~0.73) but overall considerable uncertainty</i>	Low	<i>Does the clinic disclose the limits of evidence for mood and psychological outcomes, including that reported benefits may be low-certainty, observational, short-term, or not causally established?</i>	[24]^{viii}
Need for ongoing monitoring and preventive screening	<i>Ongoing screening is material because feminising hormone therapy does not remove the need for organ-specific healthcare. Patients may still require prostate-related care, testicular/genital assessment where</i>	Long	Not applicable	<i>Universal relevance; specific schedules vary</i>	Moderate (guideline-based)	<i>Does the clinic disclose that patients on feminising hormones still require ongoing monitoring and preventive screening based on organs</i>	[25]^{ix}

based on organs present (e.g., prostate considerations)	<i>relevant, breast-health monitoring depending on exposure and age, and general metabolic/cardiovascular monitoring.</i>					<i>present, including prostate/testicular considerations, breast-health monitoring where relevant, and cardiovascular/metabolic monitoring?</i>	
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Audit use: These checklist items do not assume that every risk will occur. They identify material domains that should be disclosed where a clinic offers, facilitates, or advertises feminising hormone therapy, especially where services are described as “safe,” “evidence-based,” or provided through an informed consent model.

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

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

ⁱ Wylie C. Hembree, Peggy T. Cohen-Kettenis, Louis Gooren et al., 'Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline', *The Journal of Clinical Endocrinology & Metabolism*, vol. 102, no. 11, 1 November 2017, pp. 3869–3903, <https://doi.org/10.1210/jc.2017-01658>, <https://academic.oup.com/jcem/article/102/11/3869/4157558>

ⁱⁱ Iris de Nie, Norah M. van Mello, Emanuel Vlahakis et al., 'Successful Restoration of Spermatogenesis Following Gender-Affirming Hormone Therapy in Transgender Women', *Cell Reports Medicine*, vol. 4, no. 1, 17 January 2023, article 100858, <https://doi.org/10.1016/j.xcrm.2022.100858>, PMC: <https://pmc.ncbi.nlm.nih.gov/articles/PMC9873819/>

ⁱⁱⁱ Anna Miroshnychenko, Sara Ibrahim, Yetiani Roldan et al., 'Gender Affirming Hormone Therapy for Individuals with Gender Dysphoria Aged <26 Years: A Systematic Review and Meta-Analysis', *Archives of Disease in Childhood*, vol. 110, no. 6, 2025, article e327921, first published online 24 January 2025, <https://doi.org/10.1136/archdischild-2024-327921>, PMC: <https://pmc.ncbi.nlm.nih.gov/articles/PMC12171493/>

^{iv} Darios Getahun, Rebecca Nash, W. Dana Flanders et al., 'Cross-Sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study', *Annals of Internal Medicine*, vol. 169, no. 4, 21 August 2018, pp. 205–213, <https://doi.org/10.7326/M17-2785>, PMC: <https://pmc.ncbi.nlm.nih.gov/articles/PMC6636681/>

^v [Getahun et al., 'Cross-Sex Hormones and Acute Cardiovascular Events', 2018. https://pmc.ncbi.nlm.nih.gov/articles/PMC6636681/](https://pmc.ncbi.nlm.nih.gov/articles/PMC6636681/)

^{vi} [Getahun et al., 'Cross-Sex Hormones and Acute Cardiovascular Events', 2018. https://pmc.ncbi.nlm.nih.gov/articles/PMC6636681/](https://pmc.ncbi.nlm.nih.gov/articles/PMC6636681/)

^{vii} 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/>

^{viii} [Miroshnychenko et al., 'Gender Affirming Hormone Therapy', 2025., https://pmc.ncbi.nlm.nih.gov/articles/PMC12171493/](https://pmc.ncbi.nlm.nih.gov/articles/PMC12171493/)

^{ix} [Hembree et al., 'Endocrine Treatment', 2017. https://academic.oup.com/jcem/article/102/11/3869/4157558](https://academic.oup.com/jcem/article/102/11/3869/4157558)