



Masculinising Hormones (Testosterone): 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 testosterone 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.

Expected masculinising effects

Question: Does the clinic clearly disclose the expected masculinising effects of testosterone, including voice deepening, facial/body hair, increased muscle mass, stopping periods, expected timelines, and which effects may be irreversible or only partly reversible?

Why this matters: Testosterone is intended to cause masculinising changes — but not all changes are temporary. A young person may not realise that a deeper voice, increased hair growth, or genital changes may be permanent or only partly reversible. Families need clear information about what is likely to happen, when it may happen, and which changes may not fully reverse if treatment stops.

Fertility

Question: Does the clinic disclose potential fertility impairment from testosterone, the uncertainty of reversibility, the possibility but non-guarantee of resumed ovulation, and the need for fertility counselling or preservation discussion before treatment?

Why this matters: Testosterone may affect ovulation, ovarian function, and future reproductive options. Some people may resume ovulation after stopping testosterone, but this is not guaranteed. Parents and young people should not be reassured by vague statements like 'fertility may return' without being told about uncertainty, individual risk, and the option of fertility counselling before treatment begins.

Raised red blood cell levels (erythrocytosis)

Question: Does the clinic disclose erythrocytosis risk, blood-monitoring requirements, risk factors such as dose, route, smoking, BMI and age, management options, and possible clotting implications if hematocrit becomes significantly elevated?

Why this matters: Testosterone can raise red blood cell levels. This is usually something doctors can monitor with blood tests, but it can require dose changes, switching how testosterone is given, managing risk factors, or stopping treatment. If levels become too high, there may be increased concern about clotting risk, especially for people with other health risks.

Cardiovascular risk

Question: Does the clinic disclose known and uncertain cardiovascular risk domains for testosterone, including blood clots, stroke, heart attack, individual risk factors, and the limits of available long-term or regimen-specific evidence?

Why this matters: Some available studies may appear reassuring, but that does not mean every long-term risk is settled. Risk may depend on the person, their health history, dose, treatment route, and how long they are on testosterone. Proper consent should explain both what is known and what remains uncertain — especially for young people who may be making decisions with lifelong implications.

Bone health

Question: Does the clinic disclose possible bone density implications of testosterone, especially where treatment follows puberty blockers or gonadectomy, and explain any bone-health monitoring plan or uncertainty in long-term outcomes?

Why this matters: Bone health can be affected by sex hormones, puberty suppression, removal of gonads, dose adequacy, and whether treatment is taken consistently. Testosterone may support bone density in some contexts, but monitoring may still be needed. Families should understand whether bone health will be checked, what risks are known, and where long-term outcomes remain uncertain.

Psychological outcomes

Question: Does the clinic disclose the limits of evidence for psychological outcomes, including that reported short-term improvements may come from low-certainty observational or before-and-after studies and may not prove causal or lasting mental health benefit?

Why this matters: Testosterone may be presented as improving distress, wellbeing, depression, or anxiety. But if the evidence is mostly short-term or observational, it cannot prove that testosterone itself caused the improvement, or that benefits will last. Young people and parents deserve honest information about the limits of the mental-health evidence before making treatment decisions.

Ongoing screening and preventive healthcare

Question: Does the clinic disclose that patients on testosterone still require ongoing monitoring and preventive screening based on organs present, including cervix, uterus, ovaries, breast/chest tissue where relevant, fertility/pregnancy considerations, and jurisdiction-specific screening guidance?

Why this matters: Taking testosterone does not remove the need for sex-organ-specific healthcare. A person may still need cervical screening, checks related to the uterus or ovaries, pregnancy counselling where relevant, and monitoring based on the organs they still have. Consent should make clear that masculinising 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

This appendix sets out one of the evidence-derived disclosure domains (Masculinising 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. The following table is colour coded for compliance to the 'Checklist item derived' column, as found by audit:

Yes	No	Partial/Unclear
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TABLE 3: MASCULINISING HORMONES CONSEQUENCES (FEMALE ON TESTOSTERONE)

Note: These disclosure domains are included because testosterone produces both expected masculinising effects and potential medical consequences. Informed consent requires distinguishing intended effects from adverse effects, identifying which changes may be irreversible, explaining fertility and screening implications, and disclosing where evidence remains limited or uncertain.

<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 physical effects (voice deepening, facial/body hair, increased muscle mass; amenorrhea)</i>	<i>These are the expected treatment effects, but some may be irreversible or only partly reversible. Consumers need to understand which changes are likely, which may be permanent, and how timing, dose, and duration may affect outcomes.</i>	<i>Med.</i>	<i>Some irreversible (voice, hair, genital changes); some reversible (fat distribution)</i>	<i>Common/ expected; varies by dose and duration</i>	<i>Moderate</i>	<i>Does the clinic clearly disclose the expected masculinising effects of testosterone, including voice deepening, facial/body hair, increased muscle mass, amenorrhea, expected timelines, and which effects may be irreversible or only partly reversible?</i>	[26]
<i>Potential fertility impairment; ovulation may resume after stopping in some</i>	<i>Fertility is material because testosterone may affect ovulation, ovarian function, future reproductive options, and timing of fertility preservation. Because reversibility is variable and not guaranteed, consumers should not be reassured by general statements that fertility may return after stopping.</i>	<i>Med.– Long</i>	<i>Variable; not guaranteed; depends on age, duration, ovarian reserve</i>	<i>Quantified incidence uncertain; robust comparative fertility studies limited</i>	<i>Low</i>	<i>Does the clinic disclose potential fertility impairment from testosterone, the uncertainty of reversibility, the possibility but non-guarantee of resumed ovulation, and the need for fertility counselling or preservation discussion before treatment?</i>	[27] ⁱⁱ

Disclosure domain	Why material to consent	Typical timeline	Reversibility	Estimated frequency (or range)	Evidence quality	Checklist item derived	Key citations
Erythrocytosis (elevated hematocrit)	<i>Erythrocytosis is a known and clinically monitorable adverse effect of testosterone. It is material because it may require blood-test monitoring, dose adjustment, route changes, risk-factor management, or cessation, and may affect thrombotic risk depending on severity and comorbidities.</i>	<i>Med.– Long</i>	<i>Usually reversible with dose/route adjustment or cessation; thrombosis risk depends on severity and comorbid risk factors</i>	<i>In a cohort: 11% had Hct >0.50; 3.7% >0.52; 0.5% >0.54 (definitions vary)</i>	<i>Moderate</i>	<i>Does the clinic disclose erythrocytosis risk, hematocrit monitoring requirements, risk factors such as dose/route/smoking/BMI/age, management options, and possible thrombotic implications if hematocrit becomes significantly elevated?</i>	[28]ⁱⁱⁱ
Cardiovascular events (VTE/stroke/MI)	<i>Cardiovascular risk is material even where evidence does not show a clear elevated risk in all analyses, because long-term regimen-specific risks remain uncertain and may vary by individual risk profile. Consent should distinguish between reassuring available data and unresolved uncertainty.</i>	<i>Long</i>	<i>Not applicable</i>	<i>In large U.S. cohort, transmasculine cumulative incidence curves largely similar to reference cohorts in most analyses; precise regimen-specific risks uncertain</i>	<i>Low– Moderate</i>	<i>Does the clinic disclose known and uncertain cardiovascular risk domains for testosterone, including VTE, stroke, myocardial infarction, individual risk factors, and the limits of available long-term or regimen-specific evidence?</i>	[29]^{iv}

Disclosure domain	Why material to consent	Typical timeline	Reversibility	Estimated frequency (or range)	Evidence quality	Checklist item derived	Key citations
Bone density changes	<i>Bone health is material because sex hormone exposure, prior puberty suppression, gonadal status, dose adequacy, and adherence may affect long-term skeletal outcomes. Even where testosterone may support bone density, monitoring and uncertainty remain relevant.</i>	Long	<i>Partly reversible and may improve with adequate testosterone exposure</i>	<i>In long-term follow-up after adolescent blockers, bone outcomes appeared more favorable in those receiving testosterone than estrogen (site-specific)</i>	Low	<i>Does the clinic disclose possible bone density implications of testosterone, especially where treatment follows puberty blockers or gonadectomy, and explain any bone-health monitoring plan or uncertainty in long-term outcomes?</i>	[30]^v
Psychological outcomes	<i>Psychological outcomes are material because testosterone is often presented or understood as improving distress, wellbeing, depression, or anxiety. Where evidence is largely observational, short-term, or pre–post in design, consumers need to know that causality and long-term mental health benefit are uncertain.</i>	Med.	Variable	<i>Adolescent hormone review notes short-term psychological improvements mainly in pre–post studies; causality uncertain</i>	Low	<i>Does the clinic disclose the limits of evidence for psychological outcomes, including that reported short-term improvements may come from low-certainty observational or pre–post studies and may not prove causal or durable mental health benefit?</i>	[31]^{vi}

Disclosure domain	Why material to consent	Typical timeline	Reversibility	Estimated frequency (or range)	Evidence quality	Checklist item derived	Key citations
Need for ongoing monitoring and preventive screening based on organs present (uterus/cervix, etc.)	<i>Ongoing screening is material because testosterone does not remove the need for sex-organ-specific preventive healthcare. Consumers may need cervical screening, pelvic/uterine/ovarian assessment where clinically indicated, pregnancy counselling where relevant, and long-term monitoring based on organ inventory.</i>	<i>Long</i>	<i>Not applicable</i>	<i>Universal relevance; screening standards vary by jurisdiction</i>	<i>Moderate (guideline-based)</i>	<i>Does the clinic disclose that patients on testosterone still require ongoing monitoring and preventive screening based on organs present, including cervix, uterus, ovaries, breast/chest tissue where relevant, fertility/pregnancy considerations, and jurisdiction-specific screening guidance?</i>	[32]^{vii}

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 masculinising hormone therapy, especially where services are described as “safe,” “evidence-based,” or provided through an informed consent model.

ⁱ [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)

ⁱⁱ [Miroshnychenko et al., 'Gender Affirming Hormone Therapy', 2025., https://pubmed.ncbi.nlm.nih.gov/articles/PMC12171493/](https://pubmed.ncbi.nlm.nih.gov/articles/PMC12171493/)

ⁱⁱⁱ Mads Christian Madsen, Daan van Dijk, Chantal M. Wiepjes et al., 'Erythrocytosis in a Large Cohort of Trans Men Using Testosterone: A Long-Term Follow-Up Study on Prevalence, Determinants, and Exposure Years', *The Journal of Clinical Endocrinology & Metabolism*, vol. 106, no. 6, June 2021, pp. 1710–1717, <https://doi.org/10.1210/clinem/dgab089>, PubMed: <https://pubmed.ncbi.nlm.nih.gov/33599731/>

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

^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} Jo Taylor, Alex Mitchell, Ruth Hall, Trilby Langton, Lorna Fraser and Catherine Elizabeth Hewitt, 'Masculinising and Feminising Hormone Interventions for Adolescents Experiencing Gender Dysphoria or Incongruence: A Systematic Review', *Archives of Disease in Childhood*, first published online 9 April 2024, <https://doi.org/10.1136/archdischild-2023-326670>, White Rose Research Online: <https://eprints.whiterose.ac.uk/id/document/3094964>

^{vii} [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)