



Surgery Referral Pathways: 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 where a clinic advertises or facilitates 'access to surgery,' referrals, preparation, or pathway support. **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.

Note: These checklist items are relevant where a clinic offers, facilitates, or advertises surgical referral pathways, especially where services are described as 'safe,' 'evidence-based,' or provided through an informed consent model. Informed consent requires disclosure of material downstream risks, uncertainties, irreversibility, and the limits of available outcome data.

1. Vaginoplasty: Urinary complications

Question: Does the clinic disclose that surgical pathways may involve procedure-specific urinary complications, including UTI, meatal stenosis, urethral stricture, poor urinary stream, recurrence, and possible need for further medical or surgical management?

Why this matters: Urinary complications may affect long-term function, quality of life, and the need for further treatment. Because complication rates vary by technique, surgical centre, follow-up period, and reporting method, families need both general risk disclosure and, where available, clinic or referral-network outcome data. These are not rare or theoretical risks — they are documented complications that may require ongoing medical or surgical intervention.

2. Vaginoplasty: General surgical risks and long-term dilation

Question: Does the clinic disclose general and procedure-specific surgical risks, including bleeding, infection, wound complications, anaesthesia risks, revision surgery, scarring, and long-term dilation or maintenance requirements?

Why this matters: General surgical risks, revision risk, wound complications, and the long-term burden of dilation are material because they affect permanence, daily management, recovery expectations, and future healthcare needs. Young

people and families should not be left with a generalised impression of 'access to surgery' without understanding that surgery may create ongoing obligations and complications. Dilation is not a minor inconvenience — it is a lifelong commitment.

3. Phalloplasty: Urethral fistula, prosthesis complications, sensation outcomes

Question: Does the clinic disclose that phalloplasty may involve high rates of urethral complications, prosthesis complications, staged procedures, uncertain sensation outcomes, and possible need for further surgeries?

Why this matters: Phalloplasty carries substantial functional and complication risks, especially urethral fistula or stenosis, prosthesis complications, sensation outcomes, and possible limits on standing urination. These risks are highly material because they may require staged surgery, revision procedures, prolonged recovery, and acceptance of uncertain functional outcomes. Meta-analysis reports pooled urethral fistula/stenosis at approximately 49% — this is not a minor risk.

4. Phalloplasty/Metoidioplasty: Urethral lengthening complications

Question: Does the clinic disclose urethral-lengthening risks, including fistula, stricture, recurrence, re-operation, and uncertainty caused by limited or non-standardised outcome reporting?

Why this matters: Urethral lengthening complications may be recurrent and may require additional operations. Because outcomes vary significantly by technique and reporting is not standardised, families need to understand both the possibility of repeated intervention and the uncertainty of available data. 'Complications may occur' is not sufficient — families need to know that recurrence is documented and re-operation is common.

5. Mastectomy (chest surgery): Surgical complications and irreversibility

Question: Does the clinic disclose that chest surgery is irreversible and may involve haematoma, seroma, infection, nipple complications, sensory loss, scarring, revision surgery, and variation in cosmetic or functional outcomes?

Why this matters: Mastectomy is irreversible because breast tissue is removed. Surgical complications, revision risk,

sensory changes, scarring, and nipple complications are material to consent because they affect body function, appearance, future reconstructive options, and long-term satisfaction. Young people need to understand that once breast tissue is removed, it cannot be restored, and that complications may require further surgery.

6. Gonadectomy: Permanent infertility and lifelong hormone dependence

Question: Does the clinic disclose that gonadectomy is irreversible, causes permanent infertility, may require lifelong hormone management, and has implications for bone, cardiovascular, metabolic, and general health monitoring?

Why this matters: Gonadectomy (removal of ovaries or testes) causes permanent infertility and creates lifelong dependence on appropriate hormone management to protect bone, cardiovascular, and metabolic health. This is among the most material consent issues because it affects reproductive capacity, long-term medical monitoring, and irreversible loss of gonadal function. Young people making this decision need to understand it is permanent and creates ongoing medical obligations.

7. Regret, dissatisfaction, and detransition

Question: Does the clinic disclose the possibility of regret, dissatisfaction, changed treatment goals, detransition, limited reversibility, and the evidence limitations around regret/detransition data, including loss to follow-up and inconsistent measurement?

Why this matters: Regret, dissatisfaction, detransition, or changed goals are material even where reported regret rates are low, because measurement is inconsistent, follow-up is incomplete, and reversal is often limited or impossible. Consent should include both best available estimates and the limitations of those estimates. Young people need to know that some people do regret surgery, that reversal options are limited, and that long-term follow-up data are incomplete.

This following 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.

TABLE 4: SURGERY REFERRAL PATHWAY: MATERIAL DISCLOSURE DOMAINS

Note: These checklist items are not intended to imply that the audited clinic performs these surgeries directly. They are relevant where a clinic advertises or facilitates “access to surgery,” referrals, preparation, or pathway support. In that context, informed consent requires disclosure of material downstream risks, uncertainties, irreversibility, and the limits of available outcome data.

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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<i>Procedure</i>	<i>Consequence</i>	<i>Why material to consent</i>	<i>Typical timeline</i>	<i>Reversible?</i>	<i>Estimated frequency (or range)</i>	<i>Evidence quality</i>	<i>Checklist item derived</i>	<i>Key citations</i>
Vaginoplasty (Male)	Urinary complications (e.g., UTI, meatal stenosis, urethral stricture, poor stream), may require conservative/medical/surgical management	Urinary complications may affect long-term function, quality of life, need for further treatment, and expectations about surgical outcomes. Because complication rates vary by technique, centre, follow-up period, and reporting method, consumers need both general risk disclosure and, where available, clinic or referral-network outcome data.	Med.–Long	Often treatable; some may recur	Meta-analytic synthesis exists; procedure-specific pooled rates vary widely across complication types; standardisation needs emphasised	Low–Moderate	Does the clinic disclose that surgical pathways may involve procedure-specific urinary complications, including UTI, meatal stenosis, urethral stricture, poor urinary stream, recurrence, and possible need for further medical or surgical management?	[33] ⁱ
Vaginoplasty (Male)	General surgical risks: bleeding, infection, wound	General surgical risks, revision risk, wound complications, and the	Short–Long	Variable	Incidence varies by centre,	Low	Does the clinic disclose general and procedure-specific surgical risks, including bleeding, infection, wound	[34] ⁱⁱ

<i>Procedure</i>	<i>Consequence</i>	<i>Why material to consent</i>	<i>Typical timeline</i>	<i>Reversible?</i>	<i>Estimated frequency (or range)</i>	<i>Evidence quality</i>	<i>Checklist item derived</i>	<i>Key citations</i>
	<i>complications, anesthesia risks; possible need for revision; long-term dilation burden</i>	<i>long-term burden of dilation are material because they affect permanence, daily management, recovery expectations, and future healthcare needs. Consumers should not be left with a generalised impression of “access to surgery” without understanding that surgery may create ongoing obligations and complications.</i>			<i>technique, and follow-up; often under-reported systematically</i>		<i>complications, anaesthesia risks, revision surgery, scarring, and long-term dilation or maintenance requirements?</i>	
Phalloplasty (Female)	<i>Urethral fistula/stenosis; standing urination goals; prosthesis complications; sensation outcomes</i>	<i>Phalloplasty carries substantial functional and complication risks, especially urethral fistula/stenosis, prosthesis complications, sensation outcomes, and possible limits on standing urination. These risks are highly material because they may require staged surgery, revision procedures, prolonged recovery, and acceptance of uncertain functional outcomes.</i>	<i>Med.– Long</i>	<i>Many complications require additional surgery; some functional limits may persist</i>	<i>Meta-analysis reports pooled urethral fistula/stenosis ~48.9%; standing voiding ~91.5%; prosthesis complications ~27.9% (definitions vary)</i>	<i>Low– Moderate</i>	<i>Does the clinic disclose that phalloplasty may involve high rates of urethral complications, prosthesis complications, staged procedures, uncertain sensation outcomes, and possible need for further surgeries?</i>	[35]ⁱⁱⁱ
Phalloplasty /	<i>Urethral</i>	<i>Urethral lengthening</i>	<i>Med.–</i>	<i>Often</i>	<i>Systematic</i>	<i>Low</i>	<i>Does the clinic disclose urethral-</i>	[36]^{iv}

<i>Procedure</i>	<i>Consequence</i>	<i>Why material to consent</i>	<i>Typical timeline</i>	<i>Reversible?</i>	<i>Estimated frequency (or range)</i>	<i>Evidence quality</i>	<i>Checklist item derived</i>	<i>Key citations</i>
metoidioplasty (Female)	outcomes after urethral lengthening: fistula/stricture recurrence	complications may be recurrent and may require additional operations. Because outcomes vary significantly by technique and reporting is not standardised, consumers need to understand both the possibility of repeated intervention and the uncertainty of available data.	Long	requires re-operation; recurrence possible	review emphasises paucity of standardised data; outcomes vary by technique and staging		lengthening risks, including fistula, stricture, recurrence, re-operation, and uncertainty caused by limited or non-standardised outcome reporting?	
Mastectomy ("top surgery") (Female)	Surgical complications (hematoma/seroma, infection, nipple complications), revision surgeries; possible sensory changes and scarring	Mastectomy is irreversible because breast tissue is removed. Surgical complications, revision risk, sensory changes, scarring, and nipple complications are material to consent because they affect body function, appearance, future reconstructive options, and long-term satisfaction.	Short–Long	Irreversible (tissue removal); some issues treatable	Exact pooled complication frequencies vary; summarised evidence exists but access limitations prevented full extraction here; clinics should disclose center-specific data	Low (quantification here), Moderate (general surgical principle)	Does the clinic disclose that chest surgery is irreversible and may involve hematoma, seroma, infection, nipple complications, sensory loss, scarring, revision surgery, and variation in cosmetic or functional outcomes?	[37]
Gonadectomy (orchietomy/ophorectomy) (Male/Female)	Permanent infertility; lifelong need for hormone management to protect	Gonadectomy causes permanent infertility and creates lifelong dependence on appropriate hormone management to protect	Med.–Long	Irreversible	Frequency depends on uptake patterns; harms derive from known	Moderate (mechanistic), Low (population)	Does the clinic disclose that gonadectomy is irreversible, causes permanent infertility, may require lifelong hormone management, and has implications for bone, cardiovascular, metabolic, and general	[38]

<i>Procedure</i>	<i>Consequence</i>	<i>Why material to consent</i>	<i>Typical timeline</i>	<i>Reversible?</i>	<i>Estimated frequency (or range)</i>	<i>Evidence quality</i>	<i>Checklist item derived</i>	<i>Key citations</i>
	<i>bone/cardiometabolic health; surgical risks</i>	<i>bone, cardiovascular, and metabolic health. This is among the most material consent issues because it affects reproductive capacity, long-term medical monitoring, and irreversible loss of gonadal function.</i>			<i>physiology plus surgical complication rates</i>	<i>ation in GD pathways)</i>	<i>health monitoring?</i>	
All gender-affirming surgeries	<i>Regret/dissatisfaction; detransition (concepts overlap but differ)</i>	<i>Regret, dissatisfaction, detransition, or changed goals are material even where reported regret rates are low, because measurement is inconsistent, follow-up is incomplete, and reversal is often limited or impossible. Consent should include both best available estimates and the limitations of those estimates.</i>	<i>Long</i>	<i>Variable; some revisions possible; reversal often limited</i>	<i>Systematic review/meta-analysis reports low prevalence of regret overall but highlights heterogeneity, non-standard measurement, and incomplete follow-up</i>	<i>Low–Moderate</i>	<i>Does the clinic disclose the possibility of regret, dissatisfaction, changed treatment goals, detransition, limited reversibility, and the evidence limitations around regret/detransition data, including loss to follow-up and inconsistent measurement?</i>	[39]^{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 surgical referral pathway, 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: aww.org.au/informed-consent

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- ⁱⁱ Ding et al., 'Urinary Complications After Penile Inversion Vaginoplasty', 2023., <https://pmc.ncbi.nlm.nih.gov/articles/PMC10073518/>
- ⁱⁱⁱ Ching-Hsuan Hu, Chun-Ju Chang, Ssu-Wei Wang and Ke-Vin Chang, 'A Systematic Review and Meta-Analysis of Urethral Complications and Outcomes in Transgender Men', *Journal of Plastic, Reconstructive & Aesthetic Surgery*, vol. 75, no. 1, January 2022, pp. 10–24, <https://doi.org/10.1016/j.bjps.2021.08.00> <https://www.sciencedirect.com/science/article/abs/pii/S1748681521003843>
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- ^v Anna Miroshnychenko, Yetiani Roldan, Sara Ibrahim et al., 'Mastectomy for Individuals with Gender Dysphoria Younger Than 26 Years: A Systematic Review and Meta-Analysis', *Plastic and Reconstructive Surgery*, published online 10 September 2024, <https://doi.org/10.1097/PRS.00000000000011734>, PubMed: <https://pubmed.ncbi.nlm.nih.gov/39252149/>
- ^{vi} [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)
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