Date: [Date]

To: [Bariatric Surgeon Name]
Clinic Name: [Clinic/Hospital Name]
Address: [Clinic Address]

RE: Bariatric Surgery Candidacy Evaluation

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Insurance ID: [Insurance Number]

Dear Dr. [Surgeon Last Name],

I am writing to formally refer my patient, [Patient Name], for a consultation and evaluation for bariatric surgery. [Patient Name] has been under my care for [Duration] for the management of morbid obesity and related comorbidities.

Clinical Profile:

- **Current Weight:** [Weight]
- **Height:** [Height]
- **BMI:** [BMI Value]

Co-morbid Conditions:
The patient suffers from the following obesity-related conditions: [e.g., Type 2 Diabetes, Hypertension, Obstructive Sleep Apnea, Hyperlipidemia, GERD, Osteoarthritis].

Weight Loss History:
The patient has made multiple medically supervised attempts at weight loss over the past [Number] years, including [e.g., nutritional counseling, exercise programs, and pharmacotherapy]. Despite these efforts, the patient has been unable to maintain significant weight loss.

Medical Clearance:
In my clinical opinion, the patient is a suitable candidate for surgical intervention. They are cognitively capable of understanding the procedure and are committed to the necessary long-term lifestyle and dietary changes required for success. There are no active medical contraindications to surgery at this time.

Please evaluate [Patient Name] for the most appropriate surgical option. I will continue to provide primary care and coordinate post-operative management alongside your team.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Practice Name]
[Phone Number]
[Fax Number]