

[Date]

[Mental Health Professional Name, Degree]

[Practice Name]

[Address]

[City, State, Zip Code]

**RE: Psychiatric Clearance for Bariatric Surgery**

**Patient Name:** [Patient Name]

**Date of Birth:** [DOB]

**Insurance ID:** [Insurance ID Number]

Dear [Provider Name],

I am referring [Patient Name] to your office for a comprehensive psychological/psychiatric evaluation to determine their candidacy for bariatric surgery (weight loss surgery). This patient is currently being considered for a [Type of Procedure, e.g., Gastric Bypass or Sleeve Gastrectomy].

As part of our multidisciplinary protocol and insurance requirements, we request a formal assessment addressing the following areas:

- Current psychological stability and psychiatric history.
- Understanding of the surgical procedure and necessary life-long behavioral changes.
- History of eating disorders or maladaptive eating behaviors (e.g., binge eating).
- Presence of any substance abuse or dependency issues.
- The patient's social support system and coping mechanisms.
- Cognitive capacity to provide informed consent and adhere to strict post-operative medical regimens.

Please provide a written report including your clinical impressions and a clear statement regarding whether the patient is "cleared," "cleared with reservations/conditions," or "not cleared" at this time.

Please fax the completed evaluation to [Fax Number] or mail it to the address listed below. If you have any questions, please contact our office at [Phone Number].

Thank you for your assistance in the care of this patient.

Sincerely,

[Physician Signature]

[Physician Name, Title]

[Surgical Practice Name]