

Date: [Insert Date]

To: [Consultant Name/Cardiology Department]

Facility: [Facility Name]

Address: [Facility Address]

RE: Cardiovascular Clearance for Bariatric Surgery

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

BMI: [Current BMI]

Dear Dr. [Consultant Last Name],

I am referring this patient to your office for a formal cardiovascular evaluation and surgical risk stratification. The patient is currently a candidate for bariatric surgery ([Type of Procedure, e.g., Gastric Sleeve/Bypass]) as a treatment for morbid obesity and associated comorbidities.

Relevant Medical History:

- [Condition 1, e.g., Hypertension]
- [Condition 2, e.g., Type 2 Diabetes]
- [Condition 3, e.g., Obstructive Sleep Apnea]
- [Relevant Cardiac History, e.g., History of palpitations or Dyspnea]

Current Medications:

[List relevant medications]

Requested Evaluation:

Please provide a comprehensive cardiac assessment to determine the patient's stability for general anesthesia and major abdominal surgery. We specifically request your recommendation on:

- Current cardiac status and optimization of blood pressure.
- Need for non-invasive testing (EKG, Echocardiogram, or Stress Test).
- Perioperative management of any antiplatelet or anticoagulant therapy.
- A formal statement regarding "Cardiovascular Clearance" for the procedure.

Thank you for your expertise in the care of this patient. Please forward your consultation report to our office at [Fax Number/Email].

Sincerely,

[Signature]

[Physician Name, MD/DO]

[Practice Name]

[Phone Number]