Date: [Date]

To: [Pulmonologist Name]
[Clinic Name]
[Clinic Address]

Re: Pulmonary Function Bariatric Surgery Candidacy Evaluation

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

Dear Dr. [Pulmonologist Last Name],

I am referring this patient to your office for a comprehensive pulmonary evaluation to determine their medical readiness for bariatric surgery. The patient is currently being considered for a [Roux-en-Y Gastric Bypass / Sleeve Gastrectomy].

Please perform the following assessments as clinically indicated:

- Full Pulmonary Function Tests (PFTs) including spirometry, lung volumes, and DLCO.
- Screening or diagnostic testing for Obstructive Sleep Apnea (OSA).
- Assessment of current asthma or COPD management, if applicable.
- Clinical clearance for general anesthesia and surgical intervention.

Current Relevant History:
[Insert BMI, smoking history, or known respiratory symptoms here]

Upon completion of your evaluation, please provide a consultation report including your findings, any necessary optimizations, and your recommendation regarding surgical clearance.

Thank you for your assistance in this patient's care.

Sincerely,

[Referring Provider Signature]
[Referring Provider Name]
[Practice Name]
[Phone Number]