Date: [Date]

To: [Orthopedic Surgeon Name]
Address: [Clinic Address]
Phone/Fax: [Phone/Fax Number]

RE: Orthopedic Clearance for Bariatric Surgery
Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Insurance ID: [Insurance ID]

Dear Dr. [Orthopedic Surgeon Last Name],

The above-named patient is currently being evaluated as a candidate for bariatric surgery (weight loss surgery) at our facility. As part of our comprehensive preoperative assessment, we are requesting an orthopedic evaluation and clearance.

Patient History and Reason for Referral:

- Current BMI: [Patient BMI]
- Primary Orthopedic Concern: [e.g., Severe osteoarthritis of the knees/hips, chronic back pain]
- Impact on Mobility: [Brief description of functional limitations]

We kindly request your expert opinion regarding the following:

1. The status and severity of the patient's musculoskeletal condition(s).
2. Whether the patient's orthopedic condition(s) would benefit from significant weight loss.
3. Whether there are any contraindications or specific risks regarding the surgical procedure or postoperative physical activity.
4. Your recommendation for preoperative or postoperative physical therapy, if applicable.

Please provide a written report or a formal letter of clearance stating whether the patient is a suitable candidate for surgery from an orthopedic standpoint.

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

Sincerely,

[Referring Physician Signature]
[Referring Physician Printed Name]
[Bariatric Program Name]
[Contact Information]