

Date: [Date]

To: [Surgeon Name/Bariatric Department]

[Facility Name]

[Address]

RE: Pediatric Bariatric Surgery Candidacy Evaluation

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

BMI: [Current BMI] ([Percentile] percentile)

Dear [Surgeon Name],

I am referring [Patient Name] for a formal evaluation to determine candidacy for adolescent metabolic and bariatric surgery. This patient has been under my care for the management of severe obesity and associated comorbidities.

Clinical History:

The patient has been diagnosed with [List Diagnoses, e.g., Class II/III Obesity]. Despite [Number] months/years of supervised lifestyle interventions and multidisciplinary weight management programs, the patient has not achieved significant clinical improvement.

Comorbidities:

The patient currently presents with the following obesity-related conditions:

- [e.g., Obstructive Sleep Apnea]
- [e.g., Type 2 Diabetes / Prediabetes]
- [e.g., Hypertension]
- [e.g., Non-alcoholic Fatty Liver Disease]

Assessment:

I believe the patient and their family demonstrate the necessary developmental maturity and commitment to adhere to the required post-operative nutritional and behavioral protocols. We have discussed the risks and benefits, and they are eager to proceed with a specialist consultation.

Please find the attached medical records, recent laboratory results, and growth charts. Thank you for your evaluation and recommendations.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO/NP]

[Practice Name]

[Phone Number]