Date: [Date]

To: [Consultant Name/Bariatric Surgery Department]
Facility: [Hospital/Clinic Name]
Address: [Address]

RE: Revision Bariatric Surgery Candidacy Evaluation
Patient Name: [Patient Name]
Date of Birth: [DOB]
Insurance ID: [ID Number]

Dear Dr. [Surgeon Last Name],

I am referring [Patient Name] for a comprehensive evaluation to determine candidacy for revision bariatric surgery.

Primary Bariatric History:
The patient previously underwent [Type of Original Surgery, e.g., Gastric Band or Sleeve Gastrectomy] on [Date] performed by [Original Surgeon/Facility].

Reason for Revision Referral:
The patient is seeking a revision due to the following clinical indications:
[ ] Inadequate weight loss or significant weight regain
[ ] Severe Gastroesophageal Reflux Disease (GERD)
[ ] Persistent nausea or vomiting
[ ] Anatomical complications (e.g., pouch dilation, band slippage, or stricture)
[ ] Resolution/Recurrence of co-morbidities: [List Co-morbidities, e.g., Type 2 Diabetes]

Current Clinical Status:
Current BMI: [BMI]
Current Weight: [Weight]
Relevant Medical History: [Brief list of current conditions]

Efforts to Manage Complications:
The patient has attempted conservative management including [Dietary counseling/Medication/Behavioral changes] without successful resolution of the aforementioned issues.

I believe the patient is a suitable candidate for a surgical consultation to discuss the risks and benefits of a revisional procedure. Please find the attached recent lab results and imaging for your review.

Thank you for your expertise in evaluating this patient.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Title/Practice Name]
[Phone Number]