Date: [Date]

To: [Surgeon Name]
Facility: [Surgical Center/Hospital Name]
Address: [Address, City, State, Zip]

RE: Preoperative Medical Clearance for Bariatric Surgery

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

Dear Dr. [Surgeon Last Name],

I am writing to provide formal medical clearance for [Patient Name] for their upcoming bariatric surgical procedure ([Type of Surgery, e.g., Gastric Sleeve/Bypass]).

The patient has been under my care for [Duration of Time]. I have reviewed their medical history, performed a physical examination, and evaluated their current health status. My findings are as follows:

1. Medical History: The patient has a history of [List relevant conditions, e.g., BMI of XX, Hypertension, Type 2 Diabetes, Sleep Apnea]. These conditions are currently [Stable/Controlled/Managed].

2. Diagnostic Testing: Recent laboratory results, EKG, and [Other tests] have been reviewed. [Note any significant findings or state they are within normal limits].

3. Medications: The patient's current medications include [List medications]. I have discussed which medications should be held or adjusted prior to surgery.

4. Recommendations: [List specific perioperative instructions, e.g., DVT prophylaxis, glucose monitoring, or cardiac precautions].

Clearance Statement:
From a primary care perspective, [Patient Name] is medically stable and is cleared to proceed with bariatric surgery. The patient understands the risks and benefits of the procedure and is motivated to adhere to the necessary postoperative lifestyle changes.

If you require any further documentation or have questions, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]

[Practice Name]
[NPI Number]