Date: [Date]

To: [Surgeon Name]
Clinic/Department: [Clinic Name]
Address: [Clinic Address]

RE: Pre-Surgical Psychiatric Evaluation
Patient Name: [Patient Name]
Date of Birth: [DOB]
Proposed Procedure: [Type of Surgery]

Dear Dr. [Surgeon Last Name],

I am writing to provide the results of the psychiatric diagnostic assessment conducted on [Date of Evaluation] for [Patient Name] regarding their readiness for [Type of Surgery].

Relevant History:
The patient reports a history of [Brief summary of psychiatric history, e.g., depression, anxiety, or no history]. They are currently managed with [List medications or therapy, or state "None"].

Psychosocial Assessment:
[Patient Name] demonstrates a clear understanding of the risks, benefits, and expected outcomes of the procedure. Their expectations are [realistic/unrealistic]. The patient has identified a support system consisting of [Name/Relationship] for post-operative care.

Mental Status Examination:
At the time of evaluation, the patient was alert and oriented. Mood was [Description], affect was [Description], and thought processes were [coherent/organized]. There was no evidence of active psychosis, cognitive impairment, or active suicidal/homicidal ideation.

Diagnostic Impression:
[List ICD-10 or DSM-5 Diagnoses, or state "No psychiatric diagnosis noted"]

Recommendations and Conclusion:
From a psychiatric standpoint, [Patient Name] is considered [cleared / cleared with recommendations / not cleared] for the proposed surgery. [Optional: Recommendations for post-operative mental health follow-up].

Please contact my office at [Phone Number] if you require further information.

Sincerely,

[Your Signature]
[Your Printed Name, Credentials]
[License Number]
[Practice Name]