[Date]

[Surgeon Name]
[Clinic/Hospital Name]
[Address]
[City, State, Zip]

RE: Bariatric Psychiatric Clearance Evaluation
Patient Name: [Patient Name]
Date of Birth: [DOB]
Date of Evaluation: [Date]

Dear [Surgeon Name],

I conducted a formal psychiatric diagnostic assessment for [Patient Name] to determine their psychological readiness for [Type of Surgery, e.g., Gastric Sleeve/Bypass]. The evaluation included a clinical interview, review of psychiatric history, and assessment of current coping mechanisms and eating behaviors.

Psychiatric History and Current Status:
The patient has a history of [Diagnosis/None]. Currently, symptoms are [Stable/Well-managed/Remitted]. There is no evidence of active psychosis, severe untreated depression, or active substance use disorders that would contraindicate surgery at this time.

Behavioral and Social Assessment:
[Patient Name] demonstrates an adequate understanding of the required postsurgical lifestyle changes and dietary restrictions. The patient identifies [Name/Relation] as their primary social support. Cognitive screening indicates the patient has the capacity to provide informed consent and adhere to complex medical regimens.

Clinical Impressions and Recommendations:
Based on this assessment, [Patient Name] meets the psychological criteria for bariatric surgery. I recommend the following for postoperative success:

- Continued participation in [Individual Therapy/Support Groups].
- Regular monitoring of [Medication Name] levels (if applicable).
- Follow-up with a bariatric dietitian to reinforce behavioral goals.

Clearance Status:
From a psychiatric standpoint, the patient is **CLEARED** to proceed with bariatric surgery.

Please feel free to contact my office if you require further information.

Sincerely,

[Signature]

[Evaluator Name, Credentials]
[License Number]
[Phone Number]