[Date]

[Recipient Name/Referring Provider]
[Clinic/Organization Name]
[Address]
[City, State, Zip Code]

RE: Psychiatric Clearance Diagnostic Assessment

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Date of Evaluation: [Date]

Dear [Recipient Name],

I am writing to provide the results of the psychiatric diagnostic assessment for [Patient Name], who was referred for evaluation regarding clearance for [Specific Purpose, e.g., Bariatric Surgery, Spinal Cord Stimulator, Gender-Affirming Surgery, or Return to Work].

Clinical Assessment:
The evaluation included a comprehensive clinical interview, a review of psychiatric history, and an assessment of current mental status. [Patient Name] presented with [Brief summary of symptoms or mental state]. There is [no history / a history] of significant psychiatric hospitalization or substance use disorders that would interfere with the proposed procedure or return to duty.

Diagnostic Impression:
Based on the DSM-5-TR criteria, the patient meets the criteria for:
[Diagnosis Code/Description, or 'No diagnosis at this time']

Clearance Determination:
[Choose one and delete others:]

- The patient is deemed **Psychiatrically Cleared** for [Procedure/Action] without further restrictions.
- The patient is **Cleared with Recommendations**, provided that [Specific Conditions] are met.
- Clearance is **Deferred** at this time pending [Reason/Further Evaluation].

Recommendations:
[List any follow-up care, therapy, or medication management required].

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

Sincerely,

[Your Signature]
[Your Printed Name, Credentials]
[Title/Practice Name]