Date: [Date]

To: [Surgeon Name]
Clinic: [Surgical Practice Name]
Fax/Email: [Contact Information]

RE: Conditional Psychological Clearance for Bariatric Surgery

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

Dear [Surgeon Name],

I conducted a pre-surgical psychological evaluation for [Patient Name] on [Date of Evaluation] to determine their readiness for [Type of Surgery, e.g., Gastric Bypass/Sleeve Gastrectomy]. The evaluation included a clinical interview and [List Assessments, e.g., MBMD, MMPI-3, or PHQ-9].

At this time, I am providing a **Conditional Clearance** for the patient to proceed with surgery. While the patient demonstrates an understanding of the procedure and the necessary lifestyle changes, the following requirements must be met prior to the final surgical date:

- **Requirement 1:** [e.g., Completion of 4 consecutive smoking cessation counseling sessions]
- **Requirement 2:** [e.g., Demonstration of consistent weight tracking and food logging for 30 days]
- **Requirement 3:** [e.g., Stabilization of depressive symptoms through medication management]
- **Requirement 4:** [e.g., Attendance at a bariatric support group meeting]

Once the patient has provided documentation of these requirements, I will issue a final letter of clearance. I recommend that the patient continues therapeutic support post-operatively to address [Specific Concern, e.g., emotional eating or body image adjustment].

Please feel free to contact my office at [Phone Number] if you have any questions regarding these conditions.

Sincerely,

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