[Date]

[Surgeon Name]
[Surgical Practice Name]
[Address]
[City, State, Zip Code]

RE: Psychological Clearance for Bariatric Surgery

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

Dear [Surgeon Name],

I am writing to provide the results of the psychological evaluation for [Patient Name], who is seeking [Type of Surgery, e.g., Gastric Sleeve/Bypass]. The evaluation consisted of a clinical interview and standardized psychological testing including [Names of Tests, e.g., PAI, MMPI, or BDI].

Clinical Findings:
The patient demonstrates a clear understanding of the surgical procedure, required lifestyle changes, and potential risks. They have identified a stable support system and have realistic expectations regarding weight loss outcomes. No active untreated major mental health disorders, cognitive impairments, or active substance abuse issues were identified that would contraindicate surgery at this time.

Relevant History:
[Brief mention of weight history, previous dieting attempts, or managed mental health history].

Recommendations:
The patient is encouraged to [Specific Recommendations, e.g., attend a monthly support group or continue individual therapy] post-operatively to ensure long-term success.

Conclusion:
Based on the clinical data, [Patient Name] is **psychologically cleared** to proceed with bariatric surgery. I believe the patient is prepared to adhere to the necessary post-surgical behavioral and nutritional protocols.

If you require any further information, please contact my office.

Sincerely,

[Your Signature]

[Your Printed Name, Credentials]

[License Number]
[Phone Number]
[Email Address]