Date: [Date]

To: [Surgeon Name]
Facility: [Surgical Center/Hospital Name]
Address: [Street Address, City, State, Zip]

RE: Psychological Evaluation for Bariatric Surgery

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Insurance ID: [Policy Number]

Dear [Surgeon Last Name],

I am writing to provide the results of the psychological evaluation conducted on [Date of Evaluation] for [Patient Name], who is seeking [Type of Surgery, e.g., Gastric Bypass/Sleeve Gastrectomy]. This evaluation was performed to satisfy insurance requirements and to assess the patient's behavioral and emotional readiness for surgery.

Clinical Assessment:
The evaluation included a clinical interview and the administration of [List Tests, e.g., MBMD, MMPI-2, or PHQ-9]. The patient demonstrated a clear understanding of the surgical procedure, the necessary lifelong lifestyle modifications, and the potential risks involved.

Findings:
The patient currently meets the following criteria:

- Cognitive capacity to provide informed consent.
- Absence of untreated or unstable major psychiatric disorders.
- Understanding of post-operative nutritional and exercise requirements.
- Identification of a functional social support system.
- Commitment to long-term follow-up care.

Psychological Recommendation:
Based on the clinical findings, [Patient Name] is **cleared** from a psychological standpoint to proceed with bariatric surgery. The patient is motivated and possesses the coping skills necessary to manage the post-surgical transition.

Post-Surgical Plan:
It is recommended that the patient [Optional: attend a support group / continue individual therapy / monitor for emotional eating] during the post-operative recovery phase.

If you require any further information, please feel free to contact my office at [Phone Number].

Sincerely,

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