Date: [Date]

To: [Surgeon Name]
Clinic: [Surgical Clinic Name]
Fax/Address: [Address]

RE: Bariatric Surgery Psychological Evaluation
Patient Name: [Patient Name]
Date of Birth: [Patient DOB]

Dear [Surgeon Name],

I am writing to provide the results of the psychological evaluation conducted on [Date of Evaluation] for the above-named patient to determine their readiness for bariatric surgery.

At this time, I **do not recommend** psychological clearance for [Patient Name] to proceed with surgical intervention. This decision is based on the following clinical findings:

- [Insert reason: e.g., Uncontrolled psychiatric symptoms]
- [Insert reason: e.g., Active substance use disorder]
- [Insert reason: e.g., Inability to demonstrate adequate understanding of post-operative requirements]
- [Insert reason: e.g., Active eating disorder behavior (Binge Eating/Purging)]

Clinical Recommendations:
To address these concerns and work toward future readiness, I have recommended the following steps to the patient:

1. [Recommendation: e.g., Participation in individual therapy for X months]
2. [Recommendation: e.g., Medication management and stabilization]
3. [Recommendation: e.g., Attendance at a bariatric support group]

The patient is aware of this recommendation. I am willing to re-evaluate the patient once they have demonstrated progress in the areas mentioned above for a period of [Number] months.

Please contact me if you have any questions or require further documentation.

Sincerely,

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