[Date]

To: [Bariatric Surgeon Name/Surgical Program Name]
Fax: [Surgeon Fax Number]

RE: Medical Clearance for Bariatric Surgery

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

To Whom It May Concern,

I am the Primary Care Physician for [Patient Name]. I am writing to formally provide medical clearance for my patient to undergo bariatric surgery (specifically [Procedure Type, e.g., Gastric Sleeve or Gastric Bypass]).

The patient has a current BMI of [Current BMI] and a history of obesity-related comorbidities, including:

- [Comorbidity 1, e.g., Type 2 Diabetes]
- [Comorbidity 2, e.g., Hypertension]
- [Comorbidity 3, e.g., Obstructive Sleep Apnea]

I have managed [Patient Name]'s medical care for [Number] years. In my clinical opinion, the patient is medically stable to undergo general anesthesia and this surgical procedure. The patient has been educated on the necessary lifestyle changes and is motivated to comply with the post-operative requirements.

Current Medications: [List medications or attach list]

I recommend this procedure as a medically necessary intervention to treat the patient's morbid obesity and to improve their long-term health outcomes. There are no medical contraindications to surgery at this time.

If you require any further documentation or have questions regarding this patient's medical history, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Practice Name]
[NPI Number]